HEALTH PROVIDERS IN INDIA

ON THE FRONTLINES OF CHANGE

EDITORS

KABIR SHEIKH & ASHA GEORGE

The articles in this volume elaborate on the social, professional and systemic struggles faced by different groups of health care providers, furthering the understanding of providers' roles as actors in the health systems and societies of contemporary India, as well as re-examining existing preconceptions. These include doctors (working in the public and private sectors), nurses, public health workers, counsellors, traditional practitioners and homecare providers.

Each article presents a distinctive view of a particular group of frontline health providers, based on field research or on the authors' respective experiences of working with or as providers. Advancing the case for a fuller appreciation of the complex landscape of healthcare provision in India, the volume locates frontline health providers as central figures in development.

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Kabir Sheikh and Asha George

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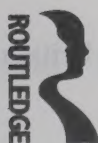
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Advance Praise for the Book

This excellent collection of new work begins to fill a major gap in our understanding of key features of the Indian health system: Who fill its positions, formal and informal, public and private sector, trained and untrained? What are their motivations, their ideals, and the everyday realities of their experiences? And how do these accommodate to, coalesce with, or conflict with major national health goals? Sheikh and George are to be congratulated for their initiative in stimulating contributors to such a well-constructed volume — one that will undoubtedly set the agenda for health-related policy-relevant research in India over the next decade.

Roger Jeffrey
University of Edinburgh

This book meets a sorely felt need in health research in India. By opening up new discussion on the diverse health providers in the country, it performs a signal service to both research and policy. Both have tended heretofore to treat the concerns and realities of health providers as either obvious or peripheral. This book bids fair to change all that, with its nuanced and rich analysis of doctors, nurses, midwives, and traditional and home-based care-givers. In addressing critical issues of needs, responsibilities, supervision and regulation at different levels, the book breaks new ground in fresh and interesting ways that will be of interest to researchers, policy makers and health activists alike.

Gita Sen
Indian Institute of Management (IIM), Bangalore

Sheikh and George have brought together a remarkable collection of perspectives on frontline health care providers in India, offering a glimpse into much neglected social, political, and cultural dimensions and determinants of their roles and practices. This book is a must-read for policymakers who are conscious of the human dimensions at the core of a responsive health care system, and for health and social science researchers, practitioners and activists seeking a sensitization to interdisciplinary and 'grounded' scholarship, with the empathetic outlook required to address India's complex health policy imperatives.

Ravi Narayan
Centre for Public Health and Equity, Bangalore

This in-depth examination of India's health providers places centre stage those who are often either ignored or just seen as a problem. Yet understanding how health providers both shape patient experience of health care and the translation of policies in practice, is critical in any effort to improve the overall performance of a health system. This volume, thus, presents rich insights for India's health policy makers — and should also stimulate policy makers and managers working in other settings. Whilst the specifics may differ, the point that health providers are central actors in any health system whose actions influence what is achieved through it, is of universal relevance. It will be an important resource for researchers and teachers in this field.

Lucy Gilson
University of Cape Town &
London School of Hygiene and Tropical Medicine

To

Nilima and Gulammohammed Sheikh

Sushila and George

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Preface and Acknowledgements

This project originated in 2006, the result of the collaborative efforts of the two editors. As doctoral scholars examining issues around health systems and health care provision in India, we observed that the treatment of frontline health providers in the available literature was insufficient, both in terms of volume and thematic breadth. The state of scholarship — fragmented, often poorly supported by empirical research, and sometimes marked by excessive abstraction and dogmatic suppositions — compared unfavourably with literature on health providers in developed nations, a profusion of learned books and articles addressing an array of sociological, political and economic issues from diverse disciplinary lenses and perspectives.

We recognised a need to consolidate knowledge in this area, and conceptualised this project. Over an absorbing three-year period, we sought out potential collaborators, invited and reviewed more than 40 abstracts and chapter ideas, and worked closely with the eventual selection of authors to develop their contributions into the versions that are presented in this volume. The chapters were all written expressly for this book, and each represents a different, distinctively Indian set of experiences, perspectives and phenomena. We hope that this collection helps bridge some of the gaps that sparked our scholarly interest.

The project was facilitated by a grant from the Sir Dorabji Tata Trust, Mumbai. We are grateful to Dr. Thomas Philip and colleagues at Partners in Development Initiatives for their support in administering and managing the grant process, and liaison with authors and publishers. Amar Jesani and Thelma Narayan, among others, provided valuable guidance

in the process of shaping the volume. It was a pleasure working with each of the contributing authors on the volume.

Personal acknowledgements are due to our friends and families for supporting us over the course of time that such an endeavour takes.

From Kabir: particular thanks to my wife Deeksha Nath for her constant encouragement and support.

This book is dedicated to our parents.

July 2009   **Kabir Sheikh**, *New Delhi*
                                                   Asha George, *New York*

List of Abbreviations

ACT-1	Name of PSI's pre-packaged kit for treatment of urethral discharge
AIDS	Acquired Immunodeficiency Syndrome
AIIMS	All India Institute of Medical Sciences, New Delhi
ANM	Auxiliary Nurse Midwife
ART	Anti-retroviral Therapy
ARV	Anti-retroviral Drugs
ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
BSW	Bachelors in Social Work
CBHI	Centre Bureau for Health Intelligence
CDO	Community Development Officer
CEO	Chief Executive Officer
CHC	Community Health Centre
CME	Continuous Medical Education
CSSM	Child Survival and Safe Motherhood
DALY	Disability Adjusted Life Year
DHO	District Health Officer
DC	District Collector
DPT	Diptheria Pertussis & Tetanus
EmOC	Emergency Obstetric Care
EPI	Expanded Programme in Immunization
FHI	Family Health International
FRU	First Referral Unit
GOI	Government of India
GUD	Genital Ulcer Disease
HAART	Highly Active Anti-retroviral Therapy
HIV	Human Immunodeficiency Virus
ICHAP	India–Canada Collaborative HIV/AIDS Project
ICPD	International Conference on Population and Development
ICTC	Integrated Counselling and Testing Centre for HIV/AIDS

IDPAD	Indo Dutch Programme for Alternatives in Development
ICSSR	Indian Council for Social Science Research
IEC	Information Education and Communication
IHC	Indigenous Healing Centre
IIM	Indian Institute of Management
IIT	Indian Institute of Technology
IUD	Intra Uterine Device
JSY	Janani Suraksha Yojana
KSAPS	Karnataka State AIDS Prevention Society
LHV	Lady Health Visitor
MBA	Master of Business Administration
MBBS	Bachelor of Medicine & Bachelor of Surgery
MCGM	Municipal Corporation of Greater Mumbai
MCH	Master of Community Health
MHW	Male Health Worker
MOHFW	Ministry of Health & Family Welfare
MPW	Multipurpose Worker
MPWM	Multipurpose Worker Male
MSc	Master of Science
MSW	Masters in Social Work
MTP	Medical Termination of Pregnancy
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NIMHANS	National Institute of Mental Health & Neuro Sciences
NLEP	National Leprosy Eradication Programme
NRHM	National Rural Health Mission
OBC	Other Backward Classes
OPD	Out Patient Department
PHC	Primary Health Centre
PHD	Public Health Department
PHN	Public Health Nurse
PHU	Primary Health Unit
PID	Pelvic Inflammatory Disease
PID	Patient Identification
PLHIV	People Living with HIV

PPTCT	Prevention of Parent to Child Transmission Programme
PSI	Population Services International
RCH	Reproductive Child Health
RH	Rural Hospital
RMP	Rural or Registered Medical Practitioner
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SAHAJ	Society for Health Alternatives (An NGO based in Gujarat)
SBA	Skilled Birth Attendant
SC	Scheduled Caste
SC	Subcentre
ST	Scheduled Tribe
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TROP	Traditional Orthopaedic Practice
UCMS	University College of Medical Sciences, New Delhi
UD	Urethral Discharge
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Childrens' Fund
VCTC	Voluntary Counselling and Testing Centre for HIV/AIDS
WCHP	Women Centred Health Project
WHO	World Health Organization
YFE	Youth For Equality

Introduction

India's Health Providers — Diverse Frontiers, Disparate Fortunes

Kabir Sheikh and Asha George

Frontline health providers are caught at the core of the many contradictions that characterise India's diverse health sector and complex development profile. While India is at the forefront of global trends in medical tourism, rural areas remain dependent on informal health providers with no recognised training. The Indian government employs a vast network of health workers, but this system is dwarfed by a dominant and largely unregulated private sector. While policy efforts to regulate medical training and practice from the many health traditions move at a glacial pace, health providers react in varied ways to the contextual pressures that influence their government service and/or private practice. These contemporary dynamics are informative and emblematic of larger developmental processes, yet remain poorly explored and understood.

An Inchoate Body of Knowledge

What do we know about frontline health providers in India? Some issues related to health providers are subject to much popular speculation and discussion. The availability of good health care, or the lack of it, is a matter of concern to all segments of society. The growth of the private medical sector, doctors' pursuit of commercial interests, quackery, complicity of doctors in organ theft and sex-selection, and apathy and corruption in government services are topics widely covered in the news, fuelling debate and opinions across all walks of life. Yet, these representations remain only the tip of the iceberg, no more than the most visible fragment of a vast inchoate body of knowledge on the subject.

Furthermore, much of the speculation around health providers is unsound. For instance, reducing the professional motivations of private doctors to pursuit of self-interest and money is at best an incomplete commentary, and at worst, one that is not constructive. As Hess and colleagues relate in Chapter 5, private practitioners have the agency and ability to contribute to public health programmes, and well-informed collaborators can assist them in actualising their public roles. When we dismiss traditional practices as quackery and fit for abolition, we ignore that traditional practitioners serve important medical as well as social functions in communities that have little access to qualified physicians.

Formal scholarship on the subject of Indian health providers is also limited. Analyses and commentaries tend to focus on problems of regulation and critique unethical practices in the private medical sector, while the policy literature, dominated by economists and development scientists, tends to view health providers as little more than resources or instruments to be manipulated in the fulfilment of policy objectives. Substantive writing on cadres of health workers other than doctors is particularly hard to come by. Traditional health practitioners is a neglected area altogether, save for a small body of writing by anthropologists. Commentaries on the health sector and systems tend to focus more on structural aspects, and not on the actors who comprise the systems.

Why is so little known, or at least so little published, about the world of India's health providers, considering the importance of the tasks they are entrusted with by society? In India, qualified doctors alone total over a million — the population of a small country. Other groups of health providers match that number, maybe even exceed it. Many questions can and should be asked about the individuals and communities that make up these numbers. What are the different worlds that these health providers live in? What roles do they play and what drives them? How do they respond to change in policies, systems and society? What relationships do they have with their patients and their peers? What kind of personal and professional struggles do they face?

Original research and reasoned, well-contextualised analysis is needed to better understand the communities and individuals

who embody our health sector. While scholars like Taylor (1976), Kirkpatrick (1979), Venkataratnam (1979), Madan (1980), Chandani (1985), Jeffery (1988), and Rohde and Vishwanathan (1995) initiated sociological interest in understanding the worlds of Indian health providers, these landmark contributions are now several years out of date. Considering the immense transformations that have affected India's health sector since these publications, it is time for a volume to bring together reflections on the varied realities of the individuals at the forefront of health service delivery in India today.

This volume consists of 12 essays by a diverse group of contributors, including health researchers, policy advocates, programme managers and a journalist, besides poems by poet-artist-physician Gieve Patel. The contributions are based either on empirical research or on the authors' experiences of working with or as providers. Each contribution presents a distinct view of a particular group of health providers. The ideas and themes that emerge from the pages that follow provoke us to re-examine many preconceptions, and so we hope that the volume will be a significant step in a more informed understanding of providers' roles as actors in the health systems and societies of contemporary India.

The Contributions

The issues that confront us, when we think about the diverse world of health providers, are multifarious, and it was a daunting task to pre-determine topics for the volume. We chose to be guided by the contributions of our authors in selecting ideas and themes that were of relevance. Resultantly, the volume embraces multiple perspectives and is interdisciplinary. Since each of these chapters is derived from field-level experiences and interactions, the volume can be said to encapsulate a 'grounded' perspective of concerns that emerge. Each chapter is a case study; hence the concentration of the volume is on depth, not breadth, of enquiry. Important universal themes still connect the different chapters.

Among the foremost emerging themes was that of government health workers' experiences of negotiating their often unstable working environments. In the first chapter, George details the

reflections of rural health assistants on the challenges faced in providing primary health care in rural communities. In doing so, she makes a persuasive case for viewing these workers in the social contexts that shape their actions. She details how health assistants perceive and negotiate gendered norms, curative hierarchies, market pressures and community scepticism with varying success. Despite their privileged positioning in rural economies, their reflections reveal their vulnerabilities, forbearance and adjustments in carrying out vital, yet poorly supported, public health mandates.

Mavalankar and colleagues, in Chapter 2, add to the literature on auxiliary nurse midwives (ANMs) by examining how their role has mutated over time from that of a midwife supporting childbirth to that of a paramedical worker, whose activities are limited to family planning, immunisation and superficial antenatal care. The authors explore past shifts in policy and programmes and how these influenced the organisational context in which ANMs work, their training and career paths. As researchers concerned about India's maternal mortality and the need to ensure skilled attendance at birth, they conclude with reflections on the more recent policy developments and their implications for strengthening the midwifery role of ANMs. Further research is required to examine more critically whether ANMs themselves see midwifery as central to their professional stature.

Vasan and Ramakrishna explore a revitalised profession — counselling. Counsellors have found renewed interest in their practice in recent years with the advent of the HIV epidemic and the consequent demand for counsellors to staff testing centres. Paradoxically, as they inhabit the world of HIV/AIDS built around a lexicon of rights and respect, these counsellors often work in contexts of discriminatory hierarchies and widespread inattention to employee and patient rights. The authors examine counsellors' struggles to integrate into hospital environments, their negotiations with management and the impact of a capricious policy environment; and underline the importance of ensuring counsellors' welfare for the success of future HIV/AIDS programmes.

In Part II of the volume, four chapters on medical practitioners engage with the tension between doctors' instincts

to further their own interests and their traditional function of serving the public good. In the first of these chapters, Baru emphasises the importance of situating the behaviour of providers within the broader context of structural changes in the national polity and society. She documents the erosion of the morale of doctors in a premier government hospital, which she contextualises within a set of distal factors — the lack of political commitment to social welfare, the changing character of middle-class India and growth of the private sector. She asserts that poor services at government health centres need to be seen in the context of the devaluation of their contribution to society, a corollary of a wholesale political shift to the right.

Presenting a converse picture of private sector enthusiasm for public health are Hess and colleagues (Chapter 5), who relate the experiences of Population Services International (PSI), a non-profit social franchising organisation, in engaging private practitioners in a public health initiative. PSI's strategy for promoting evidence-based care for sexually transmitted infections involved close contact and attention to the practitioners' needs from the collaboration, strict quality control and a practical approach to problem solving at the field level. The programme reported qualified success in aligning doctors' practices with standardised norms, but many aspects of practice remained unchanged where they conflicted with local cultural norms and with the doctors' primarily curative objectives. The need for stronger regulations in the private sector, however, remains critical, caution the authors.

Sheikh and Porter take an empathetic view of everyday decision-making by doctors working in highly contingent environments in both government and private hospitals (Chapter 6). Using an issue case study (HIV testing), they microscopically delineate practitioners' mental maps or 'appreciations' — bases for decisions in practice which balance their role — perceptions, pragmatic considerations and closely held beliefs. The practitioners are often well-intentioned, the authors observe, but work within distinct world-systems of meaning and purpose, which do not always coincide with the rationales of established public health programmes. Through this lens, the authors highlight the phenomenon of Indian

doctors' intellectual seclusion, and suggest that conceptual gaps need to be bridged to allow doctors to better actualise their public roles.

Venkatesan draws our attention outside the clinic, to the wider arena of political action. He documents a sequence of events in which sections of the medical community organised to agitate against the government's affirmative action policies, and highlights key elements which set this agitation apart from other social protest movements in the country (Chapter 6). The assurance with which parliamentary authority was challenged, the indulgent response of the judiciary, and patent, yet unquestioned, caste biases in the framing of arguments by the agitators underline the ideological power that elite doctors deploy in contemporary India, with troubling consequences for a democratic society.

Unlike Venkatesan's agitating doctors, Gieve Patel, a doctor himself, doubts and questions medical dominance. In the first of his poems at the end of this volume, titled 'Public Hospital', Patel reflects on the ephemeral nature of the power that doctors appear to hold. The final poem, 'The Multitude Comes to a Man', speaks profoundly about the unspoken bonds of trust that underlie the health care encounter:

> The multitude sees its own power
> Accumulate before
> The healing man, and exchanges
> Willingly power
> For power.

The trust between provider and patient draws its strength from the magic of healing knowledge, yet is fragile in its susceptibility to abuse. It is this same undercurrent of trust that also runs through Lohokare and Davar's accounts of encounters between faith healers and their clients with mental health infirmities, in small-town Maharashtra (Chapter 8). The accounts reveal a healing approach that is not dissimilar to contemporary psychotherapeutic approaches, but is couched in a language and context more accessible to the sufferers. In this, the third part of the book, two chapters (Lohokare and Davar, Unnikrishnan et al.) focus on traditional practitioners, and one, by Karvande and colleagues, on home care providers. These

providers are distinguished by their closeness to people and communities most in need of health care, yet lie on the peripheries of our consciousness. Rich local traditions of health are facing extinction and in this process of erosion, opportunities are lost to bridge the divide between household/local healing cultures and formal medical science. The struggle for legitimacy and acceptance is an important part of these providers' existence.

Even as debates around marginalised populations have found their place in public health discourse, the positions and contributions of these subaltern groups of providers remain largely unaddressed. Many of these subgroups of health providers are poorly researched, and indeed their presence, in many instances, has not been adequately quantified. Attempts at quantification are often problematic as marginal groups of health providers blur our perceptions of the scale of the health sector, of what is public and private care provision, and of the very nature of health care provision — one reason why we do not commence this volume with a conventional delineation of India's health sector in numerical terms of demographic composition.

The chapters on traditional providers in this volume contribute two-fold — in documenting the scale and profile of these sectors, and in highlighting their importance to communities through the languages and values that they share. Unnikrishnan and colleagues' analysis of the demographic profile of traditional orthopaedic practitioners in two south Indian states reveals the gradual decline of a transgenerational tradition. These practitioners' futures are balanced precariously between two important but often conflicting policy agendas — promotion of traditional practices, and better regulation of health care quality. Karvande and colleagues (Chapter 10) narrate four stories about people living with HIV/AIDS and their family care givers. From these complex human narratives of loss, familial compassion and the struggle for survival, important lessons for policy materialise. In India, much of care for the sick is provided by families, yet their caring role and the internal dynamics between individuals who constitute family structures and relations is hardly acknowledged. Mechanisms to support the neediest families fail to recognise the

heterogeneous needs of individuals within families and are largely inaccessible to them.

Finally, we look at the question of personal experience — the grey zone where individuality overlaps with the performance of professional roles. Sexual harassment is among the most adverse of personal experiences in the workplace. Chaudhuri analyses the experience of women who were subjected to sexual harassment in the public and private hospitals they worked in, the mechanisms they adopted to cope, and the role of administrators and co-workers in addressing the issue. Despite the ways in which sexual harassment is normalised and challenges in reporting its occurrence, colleagues are not necessarily apathetic to the problem. The views and nuances that emerge provide insights for more effective implementation of the Supreme Court guidelines on sexual harassment in the health sector and also in other workplace contexts.

Pradhan et al. tell the story of the efforts of a non-government organisation (NGO) to train male multipurpose workers in gender-sensitive practices, and the processes of realisation and change encountered by both sets of actors — trainers and trainees (Chapter 12). The interventions kick-started a process wherein health workers began reflecting on how gender norms are systemically ingrained, how their masculinities are constructed, and on the effects of gender issues on reproductive and sexual health. In the exchange, trainers also became aware of the vulnerabilities of male health workers, in the context of increasing workload and lack of investment in their development. The appreciation and trust that evolved helped evolve a cadre, often seen problematically, into valued human beings and agents of positive change.

Gieve Patel's poems conclude the contributions in this volume. The poetic medium is most suited to capture the depth of the personal experience of being a health care provider. Patel reflects on the transience of power, on the strength of the sick, and on the violence of medical intervention. The poems speak of the pain of witnessing human suffering and the doubts that beset a thinking practitioner, but through each poem, runs a subtext of dynamism and possibility. It is this possibility, of colluding in the achievement of good health, which sustains and inspires health providers in their working lives.

Charting Frontiers and Fortunes

In enacting their roles as healers and carers, and in seeking personal fulfilment and professional success, Indian health providers face encumbrances and obstacles from many quarters. Career and educational opportunities are often limited, highly competitive and increasingly uncertain. Professional livelihoods and self-confidence, at times, conflict with the rapid changes coursing through economies and health systems. Reforms are not always designed with frontline providers in mind, adding to their frustration and disillusionment. Within this background, there are many deterrents to positive action, from the vicissitudes of unregulated markets to fossilised bureaucracies and prejudiced public perceptions, each distorting the processes particular to health care provision. In their complex, changing environments, health providers can take little for granted. They struggle simultaneously on many frontiers — social, systemic, and internal — and each step they take must be negotiated carefully. The chapters in the volume record some of their varied and difficult journeys on these different paths. As members of a workforce engaged in a critical developmental activity, health providers' travails reflect those of the youthful country they inhabit, and as such, this volume is also a document of the growth pangs of India's development.

The social dimension is an important but often hidden factor shaping providers' worlds. Gender emerges as an important theme across several chapters (George; Pradhan et al.; Chaudhuri), but elements of other intersecting social characteristics, namely class and caste, and their implications for professional life, are also examined by Baru and Venkatesan. The stories of indigent families, neglected by health planners in their struggles to care for the sick, exemplify the fundamental social inequities that beset the country (Karvande et al.).

Formal health systems and structures support providers in performing their functions, but often, they are also found to be resistant to innovation and unsupportive of those in their lower echelons (George; Vasan and Ramakrishna; Sheikh and Porter). For groups such as traditional health providers, the rules of the mainstream health sector may be little more than instruments of exclusion and discrimination (Lohokare and

Davar; Unnikrishnan et al.). Uncontrolled health care markets and their irregularities affect not just private practitioners but also government health workers and practitioners, striving to maintain respect and standing among their clientele (George; Baru).

The challenges confronting medical practitioners differ qualitatively from those faced by other categories of health providers. Paradoxically, their elite status and ability to resist authority also serve to isolate and distance them from new ideas and broader processes of social change and development (Venkatesan; Sheikh and Porter). For doctors, even as they resist the limited external challenges to their dominance, the true frontiers lie within. Doctors and the collective medical fraternity must introspect, reach out beyond the insular boundaries of their profession, and reinvent themselves, if they are to regain the respect they once had in society.

We hope this book will serve as a resource and assist those engaged in health policy-making and planning, in India and globally, to be better informed by perspectives from the street, the clinic and the home — where health care encounters are enacted, and which form the settings for the 12 chapters that follow. We aim to promote an approach to policy-planning which is grounded in field-level processes and on the prevailing realities of societies, organisations and markets. We are also invested in advancing a nuanced understanding of providers' roles in health systems and in society, not only as instruments but also as instigators of change. Finally, we hope that the book may facilitate a revitalised understanding of health providers, and focus on them and their lives as a distinct subject of sociological enquiry.

This collection of chapters is unusual in the diversity of the authors and their disciplinary antecedents. The contributions emerge from different traditions of knowledge production, which makes for a variegated reading experience. This is deliberate — our inclusive approach is engineered to reflect the multifaceted nature of health providers' work and lives, and the complex tapestry of perspectives and approaches to issues surrounding them.

However, the volume is not comprehensive in any sense of the word — neither in the range of health providers covered, or in the thematic content. In spite of our efforts to be inclusive,

there are some notable omissions. The profession of nursing is one that often goes unappreciated, and unfortunately, nurses remain relatively neglected in this volume, despite repeated attempts to engage practitioners and scholars on the subject matter. Similarly, it was difficult to find and encourage colleagues to undertake research on the caste and class dimensions of health providers, on the transformations taking place in medical education, and on the role of patient networks and consumer groups in engaging with providers. Not enough research has been carried out on the large private sector and the role of private corporations in transforming the landscape and image of health care in cities. Despite the exodus of trained health providers from less developed regions to seek opportunities in larger cities and even foreign countries, another significant theme that remains unaddressed is that of migration, its personal and professional ramifications, and its effect on health systems. These neglected themes reflect biases in scholarship, and the methodological challenges of capturing some of these dimensions of the character and behaviour of health provider character and behaviour.

In spite of these omissions, we are optimistic that the volume will contribute to a renewed appreciation of this ancient and essentially human occupation and its protagonists — health providers — in the diverse contexts that make up the reality of modern India.

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PART I GOVERNMENT HEALTH WORKERS: UNEASY AT THE BOTTOM

Chapter 1

Government Rural Health Assistants as Social Beings

Neither Passive nor Perverse

Asha George

Health workers are easily maligned, especially when it is difficult to pinpoint responsibility in a vast health system that is as complex, diverse and unregulated as India's. Corrupt, self-serving bureaucrats and profiteering private doctors are both feared and abhorred. This extraordinary deviance is what captures popular sentiment and public frustration, as well as rhetoric on good governance from politicians, administrators and donors alike. My research did encounter politically connected health workers with lucrative practices in both the public and private sectors.

At the same time, my findings also revealed poor service delivery outcomes due to more pervasive, yet ordinary responses of health workers coping with their everyday, inequitable work environments. The structural inadequacies of these working environments are well known (Iyer and Jesani 1995; Koenig and Khan 1999; Mohan et al. 2003). Government health workers in rural areas cope with poor housing conditions, unreliable transport systems, unpredictable drug supplies and inadequate schooling for their children. Notwithstanding the importance of these tangible factors, in terms of infrastructure and logistics, less attention is paid by policy makers to the less visible, social experiences of providing primary health services within a government context.

Indeed conventional analysis of health worker responses to such poor working environments follows a narrative of passive demoralisation or lack of motivation. This is a direct result of motivation being primarily defined solely on the basis of health

service delivery needs, without taking due consideration of the subjective views of health workers as members of local communities with professional and social needs (Kyaddondo and Whyte 2003). This narrow definition of motivation constricts our understanding of the nuanced reflections and varied responses that one would expect from any social beings, including ordinary health workers. Following more contextualised analysis, an emerging literature is documenting the consideration of health workers as social actors who make discerning choices albeit in constrained circumstances (Kyaddondo and Whyte 2003; Walker and Gilson 2004; Penn-Kekana et al. 2004; Mathole et al. 2005; Lindelow and Serneels 2006; Mathauer and Imhoff 2006; Manongi et al. 2006; Dieleman et al. 2003, 2006).

In concordance with such work, this chapter seeks to describe the social experiences of providing primary health care services from the perspective of government health assistants, highlighting aspects that, although less tangible to managers, are very real to health workers on the ground. The findings focus on the informal relationships, boundaries and hierarchies that constrain and sustain government health assistants, as they negotiate the interface between health sector roles and community expectations in rural Koppal district, northern Karnataka. It details how health assistants perceive their gendered origins and differences, curative hierarchies in their workplace and community scepticism. Distinctions by cadre and seniority are, for instance, noted in terms of motivation to join the health department, household support, personal security, promotion opportunities, transfer negotiations and curative powers. In addition, commonalities such as the lack of referral backup, the impact of corruption and drug shortages, perceptions about work, professional vulnerabilities and strategies of dealing with community pressure are discussed. Health assistants emerge as neither passive victims nor perverse schemers, but rather as ordinary social beings, negotiating their daily realities through bargaining strategies and individual adjustments.

Methodology

Field research was informed by anthropological work on the social relations that underpin primary health care in low income countries (Aitken 1994; Kamat 1995; Nichter 1996; Atkinson et al. 2000; Gupta 2001; Pinto 2004). I also drew guidance from political scientists who highlight how field workers cope with their everyday work lives by simplifying complex policy directives into routines, rationales and labels for beneficiaries that justify the care given (Lipsky 1980; Goetz 2001). Although the resulting biases are not excusable, they also reflect the constraints and discrimination experienced by health workers (Jewkes et al. 1998).

This kind of contextual analysis of the engagement of health providers with the health systems they are embedded in, led me to examine health systems as a set of social relationships (Mackintosh and Gilson 2002). These relationships are not mechanistically determined, but are dynamically negotiated by actors involved in implementation (Barrett and Fudge 1981; Elmore 1979–80; Hjern and Porter 1981).

Data supporting this paper was collected in 2004 and is drawn from nine months of participant observation of government health services at primary health centres (PHCs), sub-centres and villages, and from qualitative responses drawn from a survey administered to 60 government paramedical staff (health auxiliaries, nurses, health educators and laboratory technicians), which I designed and jointly supervised. These paramedical staff work in rural government primary health care, which at the district level is structured according to a hierarchy of services based, in theory, on population norms. Tables 1.1 and 1.2 show the structure of services, the health personnel they should have and the populations they serve.

Table 1.1 *Designation of field-level auxiliary health staff by gender and seniority*

Health Assistants	Female	Male
Junior	ANMs (Auxiliary Nurse Midwife)	MHWs (Male Health Worker)
Senior	LHVs (Lady Health Visitor)	Seniors

Table 1.2 *Current district-level government health service structure*[1]

Facility	District Oversight	Population Norm	Personnel
Subcentre	District Health Officer / Zilla Panchayat[2]	5,000 people	1 ANM, 1 MHW
Primary Health Centre (PHC)	District Health Officer / Zilla Panchayat	30,000 people	1 doctor, LHV, senior male health worker, nurse, lab technician, pharmacist
Community Health Centre (CHC)	District Health Officer / Zilla Panchayat	100,000 people	3 specialists (obstetrician/ gynaecologist, paediatrician, anaesthetists), LHV, senior male health worker, health educator, nurse, lab technician, pharmacist
Taluka Hospital	District Health Officer / Zilla Panchayat	Secondary level care	
District Hospital	District Surgeon / State Health Department	Tertiary level care	

The qualitative data collected was analysed using the grounded theory approach (Strauss 1987; Miles and Huberman 1984), which bases theoretical analysis on the data collected. Interview data was sorted according to health worker category and seniority, then reviewed and grouped into broad analytical categories. Analytical notes were then made on the basis of detailed coding. As the data was reviewed, further comparisons were made, codes were refined, consistency checks made and variations assessed in order to further elaborate and corroborate the analysis that evolved.

Gendered Origins and Differences

The boundaries between personal and professional lives are often blurred, sometimes more so for certain social and

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[1] Slight variations in PHC and CHC staffing exist depending on the nature of standards that existed when the facilities were sanctioned. PHCs and CHCs are in charge of their own staff, as well as of the staff working in the sub-centres below them.
[2] Local government

professional groups (Mumtaz et al. 2003). For women, the degree of subordination or support in their personal lives has clear implications for their professional capacity. One respondent had a very strong opinion about how the health department favoured men over women. She stated, 'the health department is not proper, because ANMs and anganwadi workers do all the work, while male health staff only do supervision. The men do not do any work, but eat all the money that comes through the department for health work. Except for the medical officer, the other staff positions should be filled with just ladies. Only then can work be completed.'[3] In contrast to this explicit reference, most gender dimensions were expressed indirectly when health workers were asked about their motivation to join the health department, or about their family lives and working conditions.

In terms of the reasons why health assistants joined the health department, men and women had similar responses in some aspects, but differed in others. Men reported that their main motivation for joining the health department was economic, as did women. Some women had joined by default as they failed to get positions as teachers, the other main form of formal employment for educated women in rural areas. Like their male colleagues, neither health work nor public service figured in their reasons for joining the health department. Instead, the importance of acquiring a government job, with its concomitant economic security, social standing and bureaucratic entitlements was the foremost consideration.

Nonetheless, some women also cited the influence of peers and relatives within the health department who encouraged them to apply and female role models who inspired them. For instance, one ANM mentioned, 'My aunt was an ANM. I used to go with her to every village. Since then I had the desire to work in health.'[4] Considering the social inequalities that plague women's education in northern Karnataka, female role models may be an important factor, inspiring some women to persist with their education so that they can later become eligible for formal employment. Social class is also an enabling factor for some, as many of the women who do succeed in overcoming

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[3] LHV, Government health worker 45, PHC 6
[4] ANM, Government health worker 1, PHC 10

gender bias in education also come from higher class and caste groups. After being selected and trained, several women stayed at home until they got their government posting. This suggests that their families could afford not to have them do other work outside the home until they obtained more secure government jobs.

Gender also coloured the ways in which household support was viewed, and valued. A few women reported initial resistance or lack of support from their families. Over time, this would change, for which most ANMs were grateful for the support they received from home, mainly from their husbands. The support included having family members live with them for security reasons, help with transportation, and assistance during night deliveries and health consultations at odd hours. ANMs clearly stated that without this support, they would not be able to work. Some ANMs reported that their husbands were supportive because they also worked for the health department and they were sometimes posted as a couple to a sub-centre. In a few instances, when husbands were employed elsewhere, they left their jobs to live with their wives. The importance of secure government salaries enabled some ANMs to provide the financial basis for their families and to alter household relations.

However, this support is not always unconditional. Several ANMs reported that the main reason for not going to LHV training, a requisite for promotion, was the lack of household support. One ANM reported, 'My husband was a health worker. Although I got three chances for training to become an LHV, he said, "Why do you want to go?" That is the only deficiency in him. I wanted to become a LHV, but my husband said, "LHV training is for six months. If you go, who will cook in the house? The children's education will be spoiled. The job that you have now is sufficient, why do you want the LHV job?" That is why I did not go for the training'.[5]

Male health assistants also based their household status on their earning power. But in contrast with ANMs, they saw household support as an entitlement, not as a contributing support mechanism that may not always be available. One male health assistant noted, 'As I alone earn and provide the money

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[5] ANM, Government health worker 12, PHC 12

to run the house, they listen to me. There is no problem as such.'[6] Another echoed, 'I have 100 per cent support of my family members. We eat out of my earnings, so who will oppose me?'[7]

Another area with notable gender differences is personal security. Women repeatedly mentioned personal security as a primary concern. They reported being afraid to walk alone in between villages. Others discussed having to cope with insecure housing and inadequate lighting, harassment by villagers, and not being able to trust villagers when called for help at odd hours. In contrast, only one male health assistant answered the question about personal security. His response was, 'Personally, there is no problem, because I have all-round support. There is no problem.'[8] These responses show that the lack of infrastructural support, in terms of transport, housing and lighting, has gendered consequences for health workers, most intimately enacted through personal security. In countering security problems, having spouses who accompany them or local people they can trust is seen as essential by more senior ANMs.

Gender power relations also emerge when comparing the professional trajectories of female and male health assistants. As discussed in the next section, gender and curative hierarchies define how expertise is defined, contested and maintained among colleagues, within the walls of a clinic and in terms of community work.

Curative Hierarchies and Boundary Work

When there are no organised ways of signalling quality or effectiveness, as in the context of unregulated health care markets, patients develop their own ways of evaluating services (Leonard 2000; Kamat 2001). Government health workers reported that patients evaluate efficacy by the number, colour and packaging of tablets and injections provided. Focus group discussions with community groups revealed perceptions that more money purchased deeper and more painful injections, signifying better treatment.[9] Purchasing deep injections can be

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[6] MHW, Government health worker 13, PHC 12
[7] MHW, Government health worker 22, PHC 4
[8] MHW, Government health worker 9, PHC 11
[9] GHE focus group discussions (April 2002)

seen as something that 'stamps forcefully in the victim's experience that which must be noted and remembered' (Whyte et al. 2002). They signify efforts to create certainties and control over the body and its illness. In these ways, when disposable income permits it, curative commodities serve as a marker of health care expertise that can be visibly measured and commercially acquired to heal the sick (Greenhalgh 1987; Leonard 2000; Nichter 2002; Whyte et al. 2002; Leonard 2005).

This emphasis on visible, curative commodities places government health workers in direct competition with RMPs[10] who trade in tablets, injections, potions, electropathy etc. Even though government health workers perceive that communities prefer the visible benefits of curative care, the health department assigns primarily preventive health responsibilities to rural health assistants. In theory, health assistants should not feel compromised, as they are supposed to rely on a curative network of government services starting at the PHC. However, the reliability of this curative backup provided by their medical officers is beyond their control. A health education officer observed, 'In the villages they do not respect health assistants. People do not give us the respect that they give to the village accountant. If patients coming from the village are treated properly by the doctors, health assistants are given due respect, but if they are not treated properly by the doctors, it becomes very difficult for health assistants to work in the villages.'[11]

In some cases, not only are government health workers deemed inadequate to respond to curative, survival needs, but they are actually seen as more concerned with serving their own interests. As an LHV noted, 'We ask them to come to the hospital for delivery, but the doctor responds by asking them for money. If they don't give him the money, they are referred to another place.'[12] Corruption in particular adds to the perception that government services are callous to community needs. In this way, the unmet demand for curative care not only fuels scepticism about individual health assistants and government health services, but also exacerbates fault lines of distrust within the health department.

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[10]Rural medical practioners or 'registered' medical practitioners are providers who practice allopathic treatment with no formally recognised training.
[11]BHEO, Government health worker 17, PHC 5
[12]LHV, Government health worker 45, PHC 6

It is not just commodities that are appreciated by communities, but also the healing power of the doctors dispensing or prescribing these commodities. In my observations of government outpatient care, patients never questioned the nature of the treatment provided, except asking specifically for injections. The hierarchical social relations between patients and providers within the walls of a government clinic do not encourage questioning by patients. There is very little oral communication between patients and providers, and understanding largely takes place symbolically through ritualised routines (Whyte et al. 2002). At the beginning of the encounter, the patient expresses cryptic, monosyllabic symptoms, to which the provider responds by briefly touching the patient, listening to the patient's chest with his instruments and examining the whites of his eyes, before ending the medical encounter with the provision of prescriptions for medicines or injections. Learned providers are meant to be so wise as to already know what is wrong with the patient, without less educated patients explaining symptoms to them (Mariott 1955, cited by Neumann and Bhatia 1973).

Once outside a clinic, patients find out more about the treatment provided through a network of friends, pharmacists and village RMPs, who act as cultural brokers, helping them interpret and negotiate allopathic treatment seeking. With the aid of these brokers, some patients are able to contest the conventional power relations between patients and lower-level paramedics in government clinics. Health assistants repeatedly mentioned how they were scolded by communities for not providing drugs or not attending home deliveries. They are mindful, like village RMPs, of their reputations, especially among village elites. One male health assistant noted, 'If we do not go at the proper time or if the doctor is not there, patients complain about these things. They say that they will inform the panchayat leader. At such times, I have to pacify them and send them away only after giving them the right treatment.'[13] This echoes various statements by health assistants about the need to mollify patients despite the lack of supplies and curative skills. This shows that they are not impervious to community gossip or to complaints made to local bodies.

[13] MHW, Government health worker 29, PHC 1

Faced with such challenges, younger health assistants look forward to promotion as a means of increasing their power and authority over patients. Although ANMs know that they have valuable field experience, some feel that what matters more in the community's eyes is clinical expertise. A new ANM clarified, 'If we become seniors, we can work within the four walls of the clinic. If patients want care, they will have to come to us there. But because we work in the community, even if we go to each and every village, we don't accomplish much and we should obey what the patients say. But if it is in the clinic, they will obey us.'[14] Promotion for younger ANMs is seen as way to escape the frustrations of community-level work. One ANM said, 'If I get a chance of promotion I will surely take it, because here we cannot do anything with this false power. If we see the patient's behaviour and the community behaviour, we feel it is difficult to work in villages.'[15]

However, ANMs based at PHC headquarters, did not always agree that a clinical setting earned them more respect from communities. These ANMs shouldered their ANM responsibilities in the villages and also filled in as nurses due to the large number of vacancies in PHCs. They felt caught between medical officers and community members. 'As I am working in the PHC, I cannot go to the villages under my sub-centre. That is why people do not trust us.'[16] Male health assistants do not face this dilemma, as they are not expected to double up as nurses.

Faced with unresponsive care at PHCs, patients take out their frustrations on health assistants based in their villages. As one ANM reported, 'When I go to the field, I do not carry medicines for all the diseases. Due to shortages, we only have iron and folic acid tablets. Once a child fell from a tree and hurt its head. As I did not have even cotton to give first aid, I tied a cloth around its head and advised them to take the child to the PHC immediately. People scolded me. They said, "What work are you doing? Is this why the government pays your salary? For doing this? If you ask us to go to the hospital, why do you come to the villages at all? You are just a *dai* (traditional birth attendant)!"'[17]

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[14] ANM, Government health worker 4, PHC 11
[15] ANM, Government health worker 1, PHC 10
[16] ANM, Government health worker 10, PHC 11
[17] ANM, Government health worker 36, PHC 12

Families also argue with ANMs about the care they provide during delivery. A new ANM reported, 'If we ask them to go to the hospital, they say "If we have to go to the hospital, why do you come here" and fight with us. During delivery, as per our training, we do the delivery. But they say, "Don't touch this way." They tell us, "Give an injection, so delivery will take place soon" and fight with us. We have only Methargin injection (dilates the cervix), they say, "If you give Epidocin or Centocin injection (induces contractions) delivery will take place faster" and fight with us.'[18] Families that usually have women deliver at home, not only retain authority over the home environment, but also have strong beliefs as to what amounts to appropriate care, which do not match with the ANM's training.

In contrast to the scepticism expressed towards ANMs, communities see male health assistants as 'malaria doctors'. Although male health assistants have less formal training than ANMs, their technical expertise is visibly signalled by their ability to deploy allopathic technologies in the form of malaria tablets and blood smears. In contrast, ANMs dispense iron and folic acid tablets, which are not consumed by women due to their digestive side-effects and the fear that the tablets will make babies darker and larger than can be delivered by women.

I accompanied one male health worker on his village visit. While he was taking blood smears, he made sure he gave cough, fever and malaria tablets to every person who came up to him. The crowds that gathered around him resembled a feeding frenzy of 'free' tablets. The dynamics that were present in this village health visit differed from the dynamics I observed within the walls of a clinic. Villagers refer to most PHCs as 'hospitals'; places that lend an aura of curative authority to health workers, that subordinate the position of patients to providers. In contrast, when health workers go to villages, they bribe communities to gain goodwill and cooperation by dispensing curative commodities. Male health workers are more able to do this than female health workers.

Nonetheless, MHWs have also lost status through policy changes that have blurred their professional boundaries. Men, originally recruited as malaria or leprosy workers, were

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[18] ANM, Government health worker 35, PHC 1

converted, along with ANMs, into multipurpose workers in charge of all programmes. This results in a chaotic work environment where health workers are faced with multiple priorities simultaneously. As one male health assistant stated, 'Ideally only after the completion of one programme should another programme start. If they give us 23–27 programmes at once, not even one programme is completed.'[19] Another male health assistant concurred, 'We do not have any definite work. If we mix bread, curds and vegetables, everything together, neither can we eat it nor can we throw it away.'[20]

Furthermore, the uncertainty of when people fall ill or when women go into labour with unpredictable complications made government health assistants, particularly ANMs, feel they had little control over the timing or nature of their work. Health assistants feel they are perpetually on duty. In terms of changes that would help improve their working conditions, one ANM suggested, 'Making us work day and night should be changed.'[21]

Working day and night in understaffed rural areas was felt to affect the family lives of both male and female health assistants. It limited the time they had for their families, while the rural location of their postings constrained the services available for their children. One ANM concluded, 'We take care of all the children in the village, but we do not have time to look after our own children. We feel very bad. On the whole we can say that one who works in the health department should not have children.'[22]

Not everyone faces pressures that risk de-professionalising their work. Furthermore, remaining at the peripheral level over time also has its benefits. Not every health assistant wanted official promotion, as many receive salary increments that are equivalent to promotions but without the concomitant increase in responsibilities. Some health workers are also able to consolidate hierarchical gains within the health department through unofficial means. Some male junior health assistants and block health educators succeed in becoming unofficial, 'de facto' senior health assistants. They forfeit community work and

[19] MHW, Government health worker 29, PHC 1
[20] MHW, Government health worker 22, PHC 4
[21] ANM, Government health worker 24, PHC 5
[22] ANM, Government health worker 55, PHC 6

instead take over the policing of other health assistants' registers, maintenance of accounts and management of other administrative tasks. Most peons also work as unofficial staff nurses. In both these cases, men are able to unofficially escape their peripheral health service roles, in order to attain administrative and curative power. Women are not afforded such stealth powers.

Other health workers who have a curative edge over health assistants carefully guard their professional boundaries. Lab technicians, staff nurses and medical officers are the only ones who succeed in maintaining strict boundaries around their official job roles. They also work within the walls of a clinic. As one optometrist noted, 'Sometimes there are no patients. Patients with other ailments come, but very few of them are for me. Some days I simply sit and then go.'[23] This is in stark contrast with the unavoidable and limitless work that health assistants reported being beleaguered with.

Community Stand-offs and Bargaining

Although government health assistants face the same pressures for curative commodities as RMPs, with communities able to question their curative efficacy either directly or indirectly through reputational threats, health assistants also face scepticism from communities due to their placement in government services. This is due to a range of unresolved tensions, both historical and contemporary, between patients and health assistants. The consequences of these tensions contribute to poor cooperation between patients and health assistants.

Health assistants repeatedly stated that despite giving information to communities about services, they were not being utilised as they should be. This lack of compliance by patients places health assistants in direct conflict with their senior officers, who expect them to meet targets. An ANM said, 'If the community comes with problems, we do not go to help them. Due to this anger, when we ask them to undergo family planning operations, they scold us, which is quite natural. We have to

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[23]Technician, Government health worker 27, PHC 6

attain certain targets and when we try to reach the targets, the community takes revenge on us.'[24] Health assistants perceive that communities not only contest their authority, but also use their ability to evade public health campaigns as an avenue of dissent.

Mistrust partly exists due to the legacy of health workers harassing poor communities to fulfil quotas for sterilisation, linked to coercive family planning campaigns. Although family planning targets are no longer enforced in the aggressive way that they used to be, health workers still face enormous pressure to meet targets for preventive health campaigns like immunisation. Seen within the historical and contemporary failure of government services to meet community needs for effective curative care, these preventive campaigns are not perceived to be responsive to people's health needs and concerns (Greenhalgh 1987; Das and Das 2003). One ANM reported, 'They want all the treatment to be given in the village. If we go to help with delivery, they ask us to give injections immediately. If we don't give, they scold us and say that they do not want Polio and DPT.'[25,26]

Some health workers understand that this kind of community response is not necessarily vengeful, but reflects the predicament faced by communities. One senior male health worker noted, 'The people are very much scared to get immunisation for their children. When we tell them that it is good for the children, they tell us, "The government pays you to do this immunisation work. If something goes wrong with the children due to the vaccination, who will be responsible?"'[27]

Communities also feel that health assistants may not represent their interests when government programmes press against social norms that constrain ideal health behaviour. Sometimes, these norms are maintained not by patients themselves, but by more senior members of the family or community. For instance, an ANM explained that although one woman was in principle open to the idea of vaccinating her children, she also told the ANM, 'My mother-in-law does not

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[24] ANM, Government health worker 21, PHC 5
[25] Vaccine against diptheria, pertussis and tetanus.
[26] ANM, Government health worker 1, PHC 10
[27] Senior, Government health worker 37, PHC 10

agree. She does not want the child vaccinated. If I do not listen to her, I will have problems.'[28] Health assistants also reported that opposition from husbands was a big reason why women would decide against getting sterilised, even after initially agreeing to it.[29] Although it is demoralising for health assistants to try to achieve better health outcomes without changing contrary social norms, doing so entails social exclusion and community intolerance.

How do health assistants respond to the predicament of being caught between health department agendas and community expectations? Some reported that they needed to make special efforts to find beneficiaries and ensure that they complied with treatment through active surveillance and follow-up. If their individual efforts fail, some health assistants skilfully enlist broader community involvement that pressures individuals to comply. One ANM reported, 'There is a person who since 1998 did not immunise his child with pulse polio. Even for his second child he refused. Then we informed all the people in the village about him. When the public told that person, "As you are not getting your child immunised, which is a service given by the government, you should not use government buses either." He relented and got his child immunised.'[30] Implied in this logic is a sense of obligation to avail of services because government health workers make efforts to provide them. One ANM reported, 'When the children are getting vaccinated, we tell families, "This medicine protects against six fatal diseases. It is not available anywhere else. It has been brought to your doorstep, you should take it".'[31]

As suggested by this quote, more experienced health assistants described their relations with communities in terms of a quid pro quo negotiation that led to an implicit bargain. As one ANM explained, 'They cooperate and give us respect depending on how we take part and render service.'[32] Some health assistants emphasised that it is not just providing health services that matters, but also the way in which they respond

[28] ANM, Government health worker 48, PHC 1
[29] ANM, Government health worker 19, PHC 6
[30] ANM, Government health worker 6, PHC 11
[31] ANM, Government health worker 48, PHC 1
[32] ANM, Government health worker 21, PHC 5

to patients and their attitudes towards communities. One LHV noted, 'We should not stand outside their house and talk. When we go inside, whatever the condition of the house, we go and sit with them and advise about health matters, to which they agree and give us respect.'[33] Health assistants specifically noted the importance of empathising with patients. One male health assistant commented, 'We have to win their hearts and make them understand that by taking these tablets properly, they avoid complications later. By interacting with people, understanding their problems, telling them in a way they will understand, that is how we should make them swallow the tablets.'[34]

One ANM described community support for health assistants in the face of legal action from higher officials. She recalled, 'When I was undergoing training, I had heard of an ANM who was doing abortions. Once a girl undergoing abortion died accidentally and a case was booked against the ANM. The DHO and DC took actions against her and she was sent to jail. But people had a very good opinion about her. They spoke on her behalf and got her released from jail.'[35] Although it could not be confirmed whether this actually happened, it does demonstrate that not all health assistants view communities as dangerous and difficult places to work in.

One ANM said there is a period of fine-tuning required. 'I have adjusted myself to all the villagers. There could be a few minor problems, but there is nothing that cannot be sorted out. How the problems come up in the villages is when people have certain problems and we do not try to sort it out. If we feel that the villagers are in a lower position, then there are problems.'[36] From this point of view, negotiating community demands is not an insurmountable task for health assistants. However, it requires health workers to put aside their own class biases and respect the reciprocal nature of the relationships between themselves and villagers.

[33] LHV, Government health worker 16, PHC 5
[34] MHW, Government health worker 30, PHC 1
[35] ANM, Government health worker 4, PHC 11
[36] ANM, Government health worker 31, PHC 1

Individual Adjustments

Just as health workers become adept at negotiating settlements with patients and communities, they are key strategists in coping with the challenges of working in the institutional context of government service delivery. There are varying levels of room for negotiation, with transfers being the area where health workers succeed in resolving their needs most successfully. As the one malleable aspect of an otherwise rigid human resource structure, transfers offer the opportunity to exert some control over administrative destiny. By opening room for negotiation within the bureaucracy, transfers also generate highly profitable returns. Health workers talked about 'mutual transfer'[37] or how 'understanding must be there among health staff,[38] indirectly referring to bureaucratic favours being undertaken in exchange for money.

The meaning of transfers differs according to age and seniority in service. Younger recruits often stated that following government orders for different rural postings was an undisputed aspect of their jobs. In contrast, more senior health workers were adamant about their power to contest government orders regarding transfers. One such ANM said, 'If I get transferred elsewhere, I will get my transfer back here again. My husband is a RMP who has a good practice here and this town is convenient for my son to go to college.'[39] Older staff not only have different family commitments that make transfers problematic, but also become embedded in the communities they work in, and are therefore reluctant to go to other locations where they have to start afresh.

Another challenging issue about which health assistants have to strategise creatively is drug shortage. Rather than show up empty-handed, they sometimes ration prescriptions. As one nurse stated, 'Sometimes there is shortage of drugs, so we give the patients less medicine and adjust. Then after the drugs come, we give medicines to the patients.'[40] This has problematic consequences as incomplete treatment may lead to drug

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[37] MHW, Government health worker 7, PHC 11
[38] MHW, Government health worker 43, PHC 1
[39] ANM, Government health worker 36, PHC 12
[40] Nurse, Government health worker 12, PHC 12

resistance, or unplanned pregnancy in the case of contraception. In other instances, health workers give out placebos. One health assistant reported, 'There is a shortage of drugs at least once a month. People do not listen when we tell them this, patients do not understand. So if there is such a problem, we give iron and folic acid tablets and send them away. They say that if iron and folic acid tablets are taken there are no side effects'.[41] This strategy could also explain why communities are sceptical about the effectiveness of tablets provided by the government.

Health assistants also invest their own money in purchasing drug supplies and disposable syringes, which are more popular than government syringes that are easily blunted. In several PHCs I visited, it is routine practice to ask patients to purchase disposable syringes and tetanus toxoid vials from the tea kiosk set up outside PHC premises. Erratic drug supplies, therefore, sometimes pave the way for the commercialisation of 'free' government health care services (Killingsworth et al. 1999).

Even when there is a government facility with doctors posted there over a long period of time, their unreliable consultation times mean that health assistants feel that they are left to fend for themselves. One ANM said, 'When the doctor is not there, we ourselves give treatment and injections. In case any delivery cases come, I have to be present. In this dispensary even if nobody is there, I am always here at 8.00 am. Sometimes the doctor does not come on time, but I am always here.'[42] It is in these circumstances that even exerting a normal effort can come to be seen by health workers as an example of extraordinary persistence and good behaviour. It is also in these circumstances that the informal recruitment of ANM's husbands is vital for the functioning of government services.

Conclusion

Human resource policy tends to focus on formal aspects of contractual details, technical training requirements, geographic distribution etc. While these formal elements are important, health workers are not inanimate cogs and health systems are

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[41] MHW, Government health worker 43, PHC 1
[42] ANM, Government health worker 20, PHC 6

not automated machines. As this chapter has shown, health workers are social beings embedded in a myriad of informal relationships that influence their positions within their families, and also in the health department and the communities they serve. These informal relationships construct boundaries and hierarchies that are constantly being moulded and reshaped, sometimes ingeniously, but in ways that nonetheless reproduce social inequalities.

Gender differences influence who becomes a health assistant, and also moderates the level of household support required and provided. Although these gender differences tend to place ANMs in a disadvantaged position with regards to their male colleagues, there are also instances where ANMs are able to compensate by getting their husbands recruited as unofficial assistants. These are, however, individual adjustments that fail to reconfigure how expertise is defined and authoritatively maintained.

ANMs receive training from government institutions to become eligible for service and are required to undergo further training to be eligible to become LHVs. Male health workers are, on the other hand, trained at private institutions for a shorter period of time and do not require additional training to become senior health assistants, often assuming such positions unofficially. Furthermore, male health workers are more likely to be perceived by communities as doctors, while ANMs are perceived as little more than traditional birth attendants, even when they double up as nurses in clinics.

For these reasons, despite ANMs being seen by policy makers as crucial to service delivery, as well as being more qualified and more entitled to accommodation, in practice ANMs have less professional power than male health workers and are subordinate to them. ANMs' professional aspirations are limited by their gendered position within the health department, in particular, and within society, in general (Iyer and Jesani 1995).

Even as male health assistants fare better than ANMs, they are not immune to the blurring of boundaries around their personal and professional lives, which places them at the bottom of the hierarchy of primary health care personnel. Although they do manage to defend their expertise by resorting to unofficial promotions or curative powers, as the main point of interface with communities, all field level workers have a hard time

evading community dissatisfaction. This remains the case even when the structural inadequacies of government services and the historical legacies of health department campaigns are beyond their realm of influence. Nonetheless, experienced health workers learn how to engage in quid pro quo bargains with community members, gaining their support and cooperation in return for respectful service delivery.

As social beings, some health assistants curry favour with or are related to political elites. Most strikingly, what emerges from the conversations had in the course of the survey, is a sense of exposed vulnerability, common to the responses of health assistants. They make individual adjustments that act as strained safety nets for services that are underfunded and mismanaged at higher levels. Despite having secure government jobs, with concomitant bureaucratic entitlements, many health assistants reported being engaged in a losing battle of delivering services with few resources. Before any effort to address this situation, it cannot be assumed that health workers are either perverse miscreants or passive sloths. Any such effort must rather engage with them as active social beings who have understandable reactions to difficult circumstances.

Acknowledgements

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Chapter 2

The Midwifery Role of the Auxiliary Nurse Midwife

The Effect of Policy and Programmatic Changes

Dileep Mavalankar, Kranti Vora and Bharati Sharma

India is the world's largest democracy and the second most populous country. As one of the fastest developing economies, it boasts of a large skilled workforce and extensive health infrastructure. It was one of the first developing countries to have a national family planning programme and its primary health care programmes have substantially improved health indicators in general. Despite these accomplishments, India still has high maternal and child mortality rates, which have been stagnant since the 1990s. Significant efforts need to be realised to complete the demographic and epidemiological transition, and improve maternal and child health outcomes. This includes revisiting the role of midwifery.

In the context of rural government health services (Table 2.1), the Auxiliary Nurse Midwife (ANM) is the key field-level health worker, who interacts directly with the community, particularly for family planning, maternal and child health care. Existing research on ANMs as service providers highlights the constraints under which they work, and how this has led to a deterioration of maternal and child health services (Prakasamma 1989; Koenig and Khan 1997; Iyer and Jesani 1995). In this chapter, we add to this literature by analysing the role definition of ANMs more closely, with reference to relevant literature, policy and programme documents, national and state-level data, personal experiences of the authors, and informal discussions with health administrators.

We review historical influences and contemporary tensions in policy formulation and programme implementation. This range of data and experiences helps us explore how rural health care

services have expanded, how training and career paths for ANMs evolved, and the programmatic and policy influences that combine over time to shape the organisational context that colours ANM's midwifery roles.

Table 2.1 *Health infrastructure in a typical Indian district*

Level of Health Care Institution	Population Covered	Human Resources Available
District Hospital	2-3 million	Obstetrician, anaesthetist, pathologist, paediatrician, general doctors, nurses
First Referral Unit (FRU)	300,000-500,000	Obstetrician, general doctors, nurses
Community Health Centre (CHC)	100,000-300,000	Any specialist, general doctors, nurses
Old Primary Health Centre (PHC) at block level	100,000	General doctors (2), nurses, lady health visitors (LHVs), auxiliary nurse midwives (ANMs), multipurpose workers male (MPWM)
New PHC	30,000	General doctor, nurse, LHV, ANM, (MPWM)
Sub-centre	5,000	ANM, (MPWM)
Village-level Functionaries	1,000	ASHA

Source: Bulletin of rural health statistics, Ministry of Health and Family Welfare, Government of India, 2006

Evolution of Rural Health Services

After Independence in 1947, rural health services were established with primary health units (PHU) staffed by a doctor, a nurse midwife, a health visitor, a sanitary inspector and a female attendant (*aya*). The role of nurse midwives in PHUs was to conduct deliveries and visit the surrounding catchment population of 10,000. Sub-centres were established below PHUs to provide basic medical and delivery care at the field level. They were staffed with temporary workers, with lesser educational requirements and shorter training. These workers, called 'Auxiliary Nurse Midwives (ANMs)', were meant to undertake specific duties under professional supervision.

During the late seventies and eighties, the ratio of PHCs to population was radically changed from 1: 100,000 to 1: 30,000, to increase access to services. Correspondingly, human resource norms were revised to one ANM for every 5,000 people. This led to a rapid increase in the number of PHCs and sub-centres

(Figure 2.1), and a sudden rise in demand for trained ANMs (CBHI 2006). It was mandatory for most ANMs to stay at the sub-centre village, and this requirement was strictly enforced by medical and district health officers.[1] Within maternal health, the emphasis was on antenatal and delivery care, and there were few private health facilities in rural areas at that time.
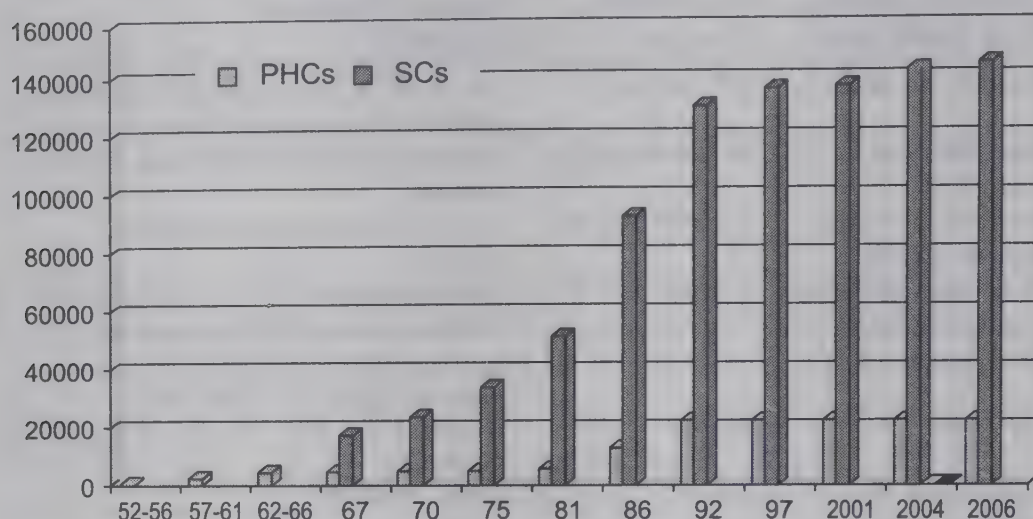
Figure 2.1 *Increase in PHCs and sub-centres in India from 1952-2004*

Since Independence, due to changes in the public sector and the growth of the private sector, the nature of the health system, the level of government service provision, and roles of health providers in India have changed dramatically.

In 1989, in four districts of Gujarat, only 5.3 per cent of deliveries were conducted by ANMs, even though more than 70 per cent of ANMs were living in their sub-centre villages (Visaria 1997). Another study showed that in 1995, in six districts of Gujarat, only 0-4.3 per cent of deliveries occurred at PHCs or sub-centres, with one district reporting no deliveries in either PHCs or sub-centres. Furthermore, attendance at birth by government health workers was only 2 and 6 per cent even in the two districts where sub-centres were constructed (UNICEF 1996). The objective of constructing sub-centres was to facilitate ANMs to stay there and attend deliveries, as well as provide other care. The same study noted that among children under five who had diarrhoea, 1.6-16.3 per cent were treated by ANMs.

This indicates that despite constructing sub-centres, ANMs delivered limited services.

[1] Communication with former additional director of Health, Gujarat 2006.

Similar results are reported for other regions in India. A rapid survey of one district in Andhra Pradesh carried out in 1998 showed that only 9.9 per cent of home births (74 per cent) were attended by ANMs (Reddy 2000).

Although ANM's role in conducting deliveries in the past has not been documented systematically, senior government officials we interviewed spoke about the change in ANM's childbirth roles due to other priorities. One senior government officer from Gujarat recounted that when he was the medical officer at a PHC 30 years ago, his PHC had 300 births per year. And when he became the district health officer about 10 years ago, he was in charge of 40 PHCs, yet the total number of births did not add up to 300 per year. Our interviews further confirm that despite significant investments in infrastructure and expansion of human resources, the absolute numbers of institutional deliveries does not seem to have been affected (Table 2.2).

Table 2.2 *Primary health services in one district of Gujarat – Then and Now*

Situation in 1960-1970s	Situation in 2005
• District with 7-12 block-level/ old PHCs covering 1,00, 000 population	• District had about 50 PHCs, each covering about 30,000 population
• Each PHC has 1-2 doctors and 3-6 sub-centres	• Each PHC had a doctor and 4-6 sub-centres
• 1 ANM per sub-centre	• 1 ANM per sub-centre
• 30-50 sub-centres per district	• 300-450 sub-centres per district
• Almost all doctor and ANMs were staying at PHC and sub-centres*	• Most doctors and ANMs were not staying in the PHC or sub-centre village. For example, Ahmedabad district had 48 PHCs, only 1-7 doctors live there**
• ANC clinic were regularly conducted at sub-centres and doctors attended them once a week*	• Only 22 per cent of ANMs stayed in the sub-centre village (Facility survey 2003)
• Deliveries were routinely conducted at PHC by doctors and HV/ANM, and at sub-centre by ANM Some PHCs were conducting about 600 deliveries a year*	• At most PHCs and sub-centres, only few or no deliveries take place. E.g. out of 48 PHCs and 351 sub-centres in Ahmedabad district, conducted about 837 deliveries in a year Only 4 out of 351 sub-centres conducted deliveries**
• Most sub-centres did not have buildings	• Only 45 per cent of sub-centres had their own buildings (Facility survey 2003)

* Based on interviews with senior district and state health managers
** Data obtained from the office of the chief district health officer of Ahmedabad

Data from the first three National Family Health Surveys (NFHS) indicates a gradual increase in institutional deliveries, but moving more towards private institutions. NFHS-III, however, shows a slight increase in deliveries in public facilities (Table 2.3). The percentage of deliveries conducted by a skilled attendant has risen, but the percentage of deliveries conducted by ANMs has remained the same for nearly 15 years, despite substantial increase in the number of sub-centres and ANMs in the country. Home deliveries by doctors have increased, so that doctors and Traditional Birth Attendants (TBAs) now attend to almost equal percentages of births. Further analysis of NFHS-III data shows that ANMs provide less than 25 per cent of women with antenatal care and 8 per cent of women with post natal care, while doctors provide more than 50 per cent of antenatal care.

Table 2.3 *Maternal health services and the contribution of ANMs, India*

Indicator in Percentage	NFHS-1 (1992-93)	NFHS-2 (1998-99)	NFHS-3 (2005-06)
I Coverage of Antenatal Services			
Completed 3 ANC visits	44	44	51
Antenatal care by ANM/LHV/Nurses	13	6	23
II Place of Delivery			
Institutional deliveries	26	34	40
Domiciliary deliveries	74	66	60
Institutional deliveries			
Public	15	16	18
NGO/Trust	NA	0.7	0.4
Private	11	17	20
III Assistance during delivery			
Doctor	22	30	35
ANM/Nurse/Midwife/ LHV	13	11	11
Other health professionals	NA	1	1
Dai (TBA)	35	35	37
Other	30	23	16
Deliveries assisted by skilled personnel (Doctor+ANM/LHV/MW+Health professionals)	35	42	49
IV Post natal care			
Post natal visit after 2 days of birth	NA	14.2	36.4
Post natal care by ANM/LHV/Nurses	NA	NA	7.9

From this evidence, it is clear that ANMs currently contribute

minimally to maternal and child health services. Their place has been increasingly taken over by doctors, mainly from the private sector. Meanwhile, TBAs continue to be an accessible human resource for childbirth. However, as per the National Programme Implementation Plan of RCH-II (2005), the national policy turned against TBAs, because they did not fit into the definition of a 'Skilled Birth Attendant'[2] (WHO 2004). The government has stopped investing in the few activities it supported with TBAs. These policy decisions leave maternity care open to the trends of the market, because there is a void of service providers within the public health system at the peripheral level.

History and Evolution of the ANM's Role

The history of midwifery and nursing training in India is not precisely documented, as it was driven by practical needs, and often undertaken informally, before the establishment of formal training institutions. It seems midwifery training preceded formal training in nursing, as the first midwifery school in the Madras Presidency started in 1854, while the first nursing school started in 1871. During the same period, candidates who failed midwifery were given a certificate for 'sick nursing'.[3] During the late 19th century, midwifery training was also offered by the many Christian mission-related hospitals for women, called 'zanana' hospitals in the Hindi-speaking areas of north India and 'lying in' hospitals in the Madras Presidency.

It was only much later that the formal establishment of an auxiliary nursing cadre took place. Prompted by the acute shortage of nurses during the 2nd World War, the Auxiliary Nursing Service was started in 1942 to provide nursing care in

[2] Skilled Birth Attendance as defined by WHO, International Confederation of Midwives (ICM) and International Federation of Gynaecologists and Obstetricians (FIGO), is 'an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.'

[3] History of nursing and midwifery in Tamil Nadu. at http://www.tamilnad unursingcouncil.com/history.asp (accessed on 15 October 2008).

military hospitals in India (Adranvala 1968). Subsequently, the Mudaliar Committee (1962) suggested continuation of this auxiliary cadre as a means to ensure basic health care at the field level (GOI 1961). Hence ANMs gradually became permanent staff in the public health system (Iyer and Jesani 1995), and were viewed as a substitute for the professional cadres posted in PHCs. ANMs were expected to provide treatment for common illnesses and to address maternal health.

In 1950 the Indian Nursing Council recommended two standard courses: a full course of three years in nursing, including a minimum of six months of midwifery, and a two-year course for ANMs, including nine months of midwifery and three months of community experience. The two-year training programme was implemented until 1977, before the Kartar Singh Committee recommended conversion of ANMs, malaria health workers and other auxiliary health staff to multipurpose health workers (Kartar Singh Committee 1974).

ANMs already in the field were given a 45-day orientation for their new role as multipurpose workers. The orientation was not adequate for their new generalist role and diluted their specific responsibilities in maternal and child health.[4]

As mentioned earlier, 1970s onwards, government infrastructure for rural health care expanded tremendously, leading to changes in health worker population norms and resulting in a great shortage of ANMs. To meet this demand in a short time, ANM training was shortened from 24 months to 18 months. The new syllabus for the training programme, while retaining classroom-based theoretical training, shortened the time for practical experience, and had less emphasis on midwifery. As seen in Table 2.4, maternal health and midwifery received only 18 per cent of the total time in the new ANM training course, and remains the same in the Indian Nursing Council's revised curriculum of 2004.

Furthermore, the shorter duration, combined with the addition of more subjects like sociology, microbiology, communicable diseases, pharmacology etc., meant that students could not effectively absorb their training (Iyer and Jesani 1995).

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[4] Personal discussion with Dr. Prakasamma, Director of Academy of Nursing Studies, Hyderabad

Table 2.4 *Time allocated to maternal health and*
midwifery in the new ANM syllabus

Subject	Theory hours	Practical hours	Total hours
Introduction to maternal health	15	15	30
Domiciliary midwifery	15	60	75
Midwifery and maternity nursing	45	75	120
Total for midwifery-related subjects	75 (11%)	150 (25%)	225 (18%)
Total hours for the whole syllabus	660	600	1260

Source: Indian Nursing Council 1983

Some ANM training schools, which were newly established
in order to meet the increasing demand of the expanding
infrastructure, did not have adequate teaching staff (Mathur;
Dua 2005).

At some places, teaching and administrative standards
deteriorated. A retired nursing tutor from Gujarat reported that
some of these schools were situated at places where the attached
hospitals did not have an adequate delivery case load for
students to get hands-on training in midwifery. Consequently,
many ANMs had inadequate practice of midwifery skills during
training. There were examples of good schools, where trainees
were getting adequate practice of conducting deliveries, but this
was not the norm. As a retired district-level officer observed,
because of this lack of practice of midwifery skills during
training, ANMs lacked the confidence to attend deliveries when
they were posted at PHCs.

More recently, a study in Rajasthan and Andhra Pradesh
showed that state governments did not have a long-term and
consistent training policy for their health staff (Gupta et al.
2005). In our experience, this is true for the majority of states
in India, with most training consisting of short-term
orientations, with little hands on learning. It is assumed that
when workers join their service, they would know most things
through their basic training.

In our opinion, given the deteriorating standards of training
in ANM schools, there should have been more emphasis on in-
service training. Yet, the Child Survival and Safe Motherhood
Programme, for example, had 11 components and devoted only
five days to training at the ANM level (MoHFW 1992). This, in
our view, was inadequate to learn the many new skills and

concepts that were brought in by the programme. As a result, many of the components in the programme remained weak, including maternal care (Mavalankar 1996, 1999).

After graduating, when first posted to a sub-centre usually in an area unfamiliar to her, most ANMs are young and unmarried. With the sub-centre building often being outside the village, it is difficult and unsafe for her to attend house calls for delivery care, especially at night. Her training does not prepare her for these field realities, where she is alone in managing obstetric complications and dealing with rural communities. Nor does the current supervision system help her address these challenges (Mohan et al. 2003). The medical officer at the PHC does not normally assist in deliveries or insert IUDs, making it difficult for the medical officer to give technical guidance to the ANM. Supervision by lady health visitors and medical officers is limited to checking registers, with little emphasis on mentoring (George 2009).

There is no career path for an ANM except becoming a lady health visitor after completing the required course. As there is only one lady health visitor post for every six to seven ANMs, only a few get a chance for promotion. There is a possibility for ANMs to qualify for a diploma in general nursing, with the government giving them deputation during the training period. However, nursing schools offering diplomas in general nursing and midwifery admit students after 12 years of school education. Very few ANMs are eligible for this, because the admission criterion for an ANM is 10 years of school education. Therefore, most ANMs start and end their careers as ANMs.

In conclusion, ANM training today does not prepare ANMs for working in rural areas and does not give them the skills to provide delivery care, let alone the complete package of reproductive and child health care. In our opinion, no authority, neither the nursing council nor the government, has paid attention to developing a career path for ANMs, which has made their job monotonous and laborious, without any rewards. Nor have policy or programme changes helped, as discussed in the following section.

Policy and Programme Changes

Two policy decisions were decisive in changing the role of ANMs. First, in 1966, the Mukherjee Committee suggested a target system to achieve family planning goals, and in the fourth Five Year Plan in 1969, maternal and child health were integrated with the family planning programme (GOI, Planning Commission 1968).

This strategy was aimed at getting better acceptance for family planning from communities. But as per our analysis, this integration decreased priority to maternal and child health as family planning was projected as the programme deserving the highest priority.

Second, in 1974, the Kartar Singh Committee noted that it was difficult to sustain many different workers appointed under various vertical disease control programmes. Instead of having disease specific workers, all auxiliary field health workers would become generic 'multipurpose' workers (Kartar Singh Committee 1974). As a result, instead of consolidating and developing a cadre of maternal and child health service providers, the government chose to broaden the role of ANMs. An ANM's responsibilities increased and spread out over family planning, immunisation, sanitation, infectious disease prevention and care, and antenatal and delivery care.

As a consequence of the first policy decision, a specific department with its own management structure was created at the central, state and district levels, with the sole function of promoting family planning through the PHC staff, some of whom were specially recruited under the family planning programme.

While in theory, all sub-centre and PHC staff had similar responsibilities, including maternal and child health, according to one senior district officer, the staff funded by the family planning programme restricted themselves to only family planning. The new ANMs employed under the family planning programme did not feel the need to stay at the sub-centre village, as their work no longer entailed services required around the clock, like attending to childbirth.

Despite a generalist profile, an excessive and overpowering focus on target-oriented family planning led to the neglect of maternal and child health services, especially delivery-related

services. Researchers and programme managers report that until recently, all the monitoring of health programmes was overshadowed by the achievement of family planning targets (Iyer and Jesani 1995). In contrast, there are no specific targets for maternal health, and the performance of ANMs is not evaluated on the comprehensive provision of reproductive health services.

Even as family planning targets have been officially removed, substantial amounts of the ANM's time is spent on motivating sterilisation cases, accompanying the motivated cases to the sterilisation camp, and attending duty on the day of the camp (Sinha 1992; Visaria and Visaria 1999).

Family planning is not the only vertically implemented programme skewing the roles of field-level staff. During the mid 1980s, the immunisation programme called the Expanded Programme in Immunization (EPI) for children below five years started to receive priority. The implementation of the programme at field level was assigned to ANMs. EPI was followed by Universal Immunisation Programme (UIP). Similar to the family planning programme, these vertically driven immunisation drives again focused ANM's attention on routinely scheduled activities, rather than being available to provide continuous services. The same is in the case of the current focus on pulse polio, which is having a detrimental effect on routine primary health care (Trivedi et al. 2009). With the government's focus on family planning and immunisation both monitored through targets, the monitoring of the midwifery activities of the ANM at the sub-centre and home got neglected (Sinha 1992, Visaria and Visaria 1999).

Subsequently, the Child Survival and Safe Motherhood Programme (CSSM) started in 1992, as a follow up to the Universal Immunisation Programme. There were eight goals of the programme out of which one was for maternal health, namely the reduction of maternal mortality. Although the package specified care at birth as a service, the work plan of the ANM at the sub-centre level did not specify conducting deliveries in the list of critical activities. Similarly this was missing from the module for planning maternal and child health services at the PHC and sub-centre level and also from the sample work plan of the ANM in the workers' manual (MoHFW

1992). Our analysis shows that the programme created a conceptual conflict through its fixed day schedule by giving more priority to routine primary preventive services such as immunisation and family planning, as compared to emergency services such as delivery care and diarrhoea management (Mavalankar 1996, 1999).

Alongside these programmes for family planning and child survival, the training of Traditional Birth Attendants (TBA) was also supported. This may have stemmed out of the realisation that ANMs were not able to assist in all the births, and that communities would take time to accept institutional deliveries.

Successful TBA training programmes have demonstrated that it is possible to train TBAs, but it takes a long and sustained effort (Mavalankar et al. 1998). Unfortunately, the government accepted TBA training without clarity about what it would take to make it work (Lawn et al. 2006; Sadgopal 2009). In addition, duration of the training programme for TBAs was brought down from the 1-3 months to six days under the CSSM programme, and one day each month for 12 months under the Reproductive and Child Health Programme.

Training TBAs also gave a sense of false security to health planners about reaching service delivery goals. For instance, the government reporting system, at some levels, clubs deliveries attended by ANMs with those attended by trained TBAs, thus inflating the indicator for safe delivery. However, the current training cannot qualify trained TBAs as skilled birth attendants.

Some argue that in developing countries, the focus on training TBAs has served to distract governments from building a cadre of skilled birth attendants, because the donors funded and supported large-scale TBA training (Starrs 2006). In India, in our view, instead of training ANMs in midwifery skills, the government spent resources on training TBAs.

These vertical shifts in the focus of national programmes mirrored the support of international agencies to the Union Ministry of Health in terms of technical assistance and funding. Most of the government's budget is committed to paying salaries. As a result, relatively small amounts of international aid can yield significant leverage that can direct national programmes in particular directions, though measuring the effectiveness of such international support is difficult.

Despite the Nairobi Safe Motherhood Conference in the late 1980s, no international agency assumed the mandate for maternal or women's health more broadly (Shiffman and Smith 2007). While UNICEF had child survival as its objective, neither the World Health Organization nor the World Bank had the grassroots presence to help governments refocus on maternal health and deliveries. The Government of India too did not have any strong advocates for maternal health (Shiffman and Ved 2007).

After the International Conference on Population and Development in 1995, there was a major conceptual shift in the national policy from family planning to comprehensive and integrated reproductive services. The Reproductive Child Health Programme (RCH-I) that spanned between 1997 and 2003 included many new components, such as adolescent reproductive health, gender, and sexually transmitted and reproductive tract diseases. The concept of obstetric services available 24 hours a day, seven days a week (24x7) at PHCs and CHCs was conceived for the first time during RCH-I.

Despite these conceptual changes, this new paradigm shift was difficult to sink into the system (Karkal 2006; Visaria et al. 1999). Among other barriers to implementation, the training and orientation for ANMs was very brief, especially considering their lack of hands-on experience (ANS 2005). As a result, RCH-I was not able to achieve its goals (MoHFW 2005).

Its successor RCH-II aims to reduce maternal deaths through promoting institutional deliveries and ensuring skilled attendance at birth (MoHFW 2005). The objectives of RCH-II include providing basic emergency obstetric care (EmOC) at sub-centre and PHC level, and comprehensive EmOC at CHC and district hospital level.

ANMs, lady health visitors and staff nurses have been allowed to give life saving drugs like misoprostol, magnesium sulphate and antibiotics for first aid to address complicated obstetric cases before referring them to a higher facility. The government has developed guidelines for skilled birth attendants, and states are using them for training these attendants.

Under the National Rural Health Mission (NRHM) launched in 2005, there is also a provision for an additional ANM at the sub-centre to provide delivery care and curative services. NRHM

also supports village-based health volunteers or Accredited Social Health Activists (ASHAs). They are selected from villages, and act as the motivators and educators to mobilise the community for desirable health seeking and health promoting behaviour, especially in the area of maternal and child health. After a short training, ASHAs receive partial monetary incentives based on the specific tasks. In addition, to promote institutional births, the government launched the Janani Suraksha Yojana (JSY), which gives financial incentives to women from Below Poverty Line (BPL) families if they go for delivery in institutions. Hence, important demand and supply side barriers are being addressed.

To summarise, the way the role of the ANMs has evolved from before to after Independence has been affected by multiple factors. Their roles and responsibilities have undergone changes according to changing national priorities and programmes.

During the 1980s and 1990s, the stress on family planning and immunisation alienated ANMs from maternal and child health, deskilling her and converting her into a multipurpose worker. The role of an ANM has changed from that of a midwife, whose main work was to carry out delivery and maternal and child health care, to a paramedical whose activities are limited to family planning, immunisation and superficial antenatal care. Governments and international agencies focused on family planning and immunisation, thereby neglecting maternal health, especially the midwifery role of ANMs.

In addition, a large number of ANMs do not reside at sub-centre villages and are therefore available only for three to five hours a day. They are not easily accessible to the community during emergencies or unpredictable events like delivery, as they travel to provide preventive care to assigned villages and are busy with other administrative work.

Though the current maternal health strategy in NRHM/RCH-II seems to support ANMs, there are unresolved issues that, if not resolved, will undermine their role. With regards to their training as skilled birth attendants, although the government has disseminated training guidelines, there is no consensus on the appropriate time required for developing birth attendance skills through in-service training. According to government guidelines, the recommended duration for training staff nurses is two weeks and that for ANMs is three weeks, which can be

extended to six weeks if the required proficiency in skills is not satisfactory (MoHFW 2008).

In contrast, according to the International Confederation of Midwives, two to three years of training may be needed for direct-entry candidates, whereas for those who have trained as nurses, 18 months or less may be enough (WHO 2006). Therefore, the training recommended for ANMs is not enough for them to qualify as skilled birth attendants according to international recommendations.

In spite of increasing the scope of practice, which is the right strategy, the short training to ANMs will not be enough to bridge the skill gap in delivery care at the periphery. At the same time, TBAs' training has been discontinued in most parts of the country, with some states emphatically distancing the TBA from childbirth. As for ASHAs, there are no plans to train them as skilled birth attendants. It appears the latest policies have left a large void in terms of who can provide skilled childbirth assistance.

In addition to these shortcomings regarding training, the issues of infrastructure and health systems remain unresolved. At the national level, 45 per cent of sub-centres do not have their own building and 79 per cent do not have tap water (Facility Survey 2003). In the absence of such basic facilities, it is not possible to provide delivery care. Furthermore, according to the survey, only about 23 per cent of ANMs stay at the headquarters.

Service delivery is influenced by the place of residence of the ANM in various ways. It affects timeliness, and the quality and range of care provided. Those who stay at the headquarters are more likely to be available to provide healthcare, because they save commuting time and are less likely to be absent from the village for personal work.

Before increasing the number of field functionaries, there is a need to improve management of human resources, logistics and infrastructure. The issue of effective mentoring and supervision of the ANM does not seem to have been addressed. Unless India learns from the failures of past programmes, it is not possible for the ANM to revert to the role of a comprehensive reproductive and child health service provider, let alone provide effective midwifery care.

Conclusion

The midwifery role of the ANM should be restored if the goal of decreasing maternal mortality mentioned in various plan documents of the Government of India have to be met. Developing countries like Sri Lanka and Malaysia have reduced maternal mortality significantly by ensuring universal access to skilled birth attendance. One of the foundations for ensuring universal access in both the countries was creating and supporting a strong cadre of registered, clinically trained community-based midwives (Pathmanathan et al. 2003). In India, ANMs can play a similar role in providing quality reproductive and child health services to rural population. To achieve this, good pre-service training, supportive supervision, recognition and rewards, and a functioning health system for backup support have to be ensured.

The priority will have to change from family planning and immunisation to comprehensive reproductive health, including maternal and neonatal care. These changes will require sustained and careful planning, and allocation of resources, rather than indiscriminate spending on more resources without simultaneous systemic reforms.

In this chapter, we have shown that despite increases in infrastructure and human resources, shortcuts taken with regards to training, lack of policies supporting career pathways, skewed vertical programming and lack of attention to crucial human resource management issues specific to ANMs have undermined their role in midwifery. Amendments are needed in national policies, as programme implementation plans require complementary and consistent policies.

Synergistic efforts among government, international agencies and non-government agencies are essential to improve the performance of ANMs for effective peripheral maternal health services. The current strategies under NRHM/RCH-II, like skilled birth attendance training, increasing the scope of practice of ANMs to provide life saving measures, and doubling the number of ANMs at sub-centres, are an excellent opportunity to strengthen the role of ANMs. Yet, this opportunity will be lost if careful attention is not paid to effective implementation, and if supportive managerial and organisational reforms do not occur.

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Chapter 3

Dilemmas and Conflicts of HIV Counsellors in VCTCs

Experiences from Karnataka

Akhila Vasan and Jayashree Ramakrishna

T he HIV/AIDS epidemic in recent years has opened up several debates touching upon issues related not only to public health but also professional ethics, human rights and the nature of development itself. HIV prevention and control programmes, while recognising the importance and centrality of psycho-social interventions, have, in their implementation, tended to be dominated by the biomedical paradigm. Even though policies have adopted the language of rights and ethics, programme strategies have remained largely within the public health domain, creating certain tensions and dilemmas.

In this chapter, we describe the various dilemmas and conflicts arising out of the interactions between a psycho-social intervention, such as a Voluntary Counselling and Testing Centre (VCTC), and the clinical setting of a district hospital. We outline the multitude of challenges counsellors face in VCTCs in Karnataka, and their interrelations with the state health machinery, the HIV programme, the medical hierarchy, and with clients.

We discuss how specific tensions and conflicts in these relationships caused counsellors to modify their practices, and caused divergences in the performance of their roles from the expected ideals. And we conclude by pinpointing critical areas of concern, particularly the erosion of core counselling principles, and highlight the need to support counsellors in the context of a changing and unstable professional environment.

Origins and Ideals of Voluntary Counselling and Testing

During the early years of the epidemic, aggressive calls for punitive, forcible testing sparked widespread concern about the effects of such strategies on individual rights and the spread of the epidemic. Community advocates, human rights activists and public health professionals collectively forged a consensus that Voluntary Counselling and Testing (VCT) was the most effective and appropriate method of encouraging HIV testing and adoption of non-risky behaviour (CHANGE 2005). UNAIDS defines VCT as 'the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he/she must be assured that the process is confidential' (UNAIDS 2000).

VCT is considered important for both prevention and care efforts. It is widely acknowledged that knowledge of one's sero-status through VCT can be a motivating force for HIV positive as well as HIV negative people to adopt safe sexual behaviour (NACO 2003d). It is seen as a key entry point for access to medical care and other support services for those who test positive (See Figure 3.1). Programme experiences have also shown that the VCT approach is effective in helping reduce the stigma and secrecy surrounding HIV/AIDS (UNAIDS/WHO 2000).

HIV counselling in the VCT process draws its content and strategies from contemporary perspectives on behaviour change that move beyond simply imparting information; towards more comprehensive approaches of providing skills training and modifying attitudes, beliefs and situational determinants of risky behaviour (Bandura 1986, 1994; Ross and Rosser, 1989; Chandra et al. 1997-98).

The VCT process is structured to be a two-part process, involving pre-test and post-test counselling. At every stage, the client is assured of confidentiality, and the process proceeds only if the client gives his/her informed consent (See Figure 3.2).
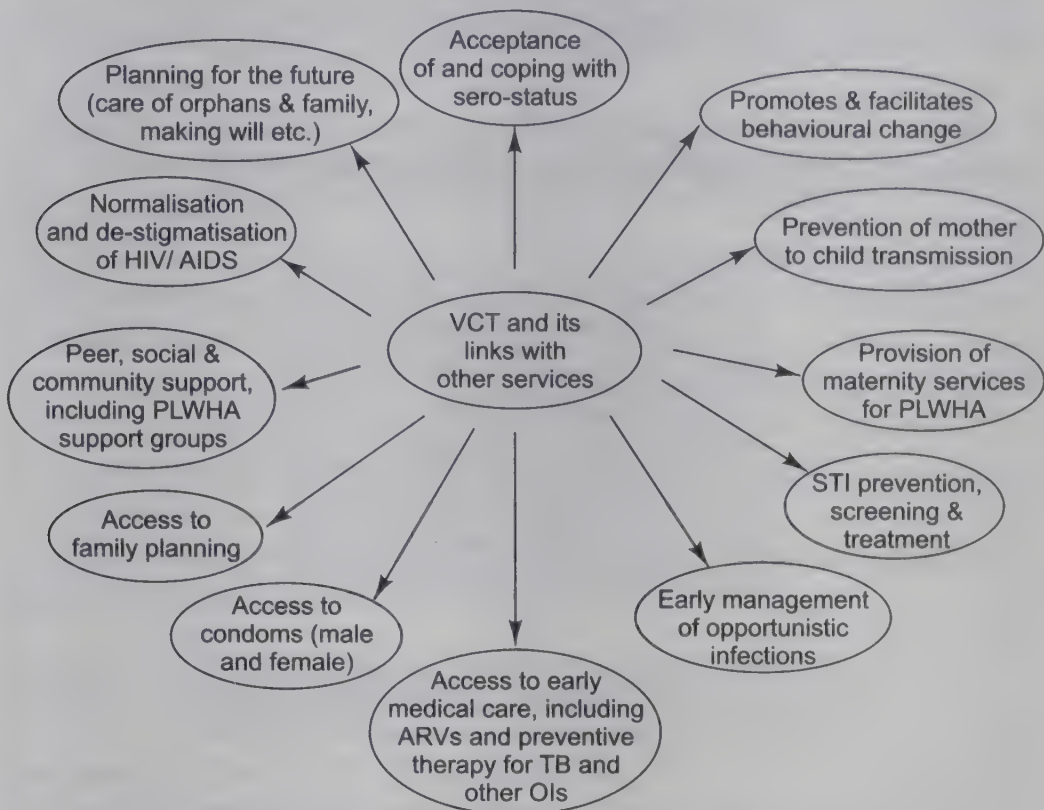
Figure 3.1 *VCT and its links with other services*

During pre-test counselling, the counsellor:

- Explores the client's HIV/AIDS knowledge and corrects any misconceptions that the client may have
- Explains what an HIV test is, the meaning of a positive or negative test result
- Assesses the risk, and helps client personalise risk
- Discusses the implications of the test result and the possibility of a potential positive result
- Explores the client's support system to cope with the result
- Jointly develops a risk reduction plan that the client feels is feasible and comfortable

If the client agrees, then his/her blood is drawn for the test and a date convenient to the client is decided for the post-test counselling session.

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┌─────────────────────────────────────────────────────┐
│         Development of Community Awareness            │
└─────────────────────────────────────────────────────┘
                          ⇩
┌─────────────────────────────────────────────────────┐
│          Decision to seek counselling testing         │
└─────────────────────────────────────────────────────┘
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        ┌───────────────────────────────────┐
        │      Pre-test counselling:         │
        │        The test process            │
        │        Test implications           │
        │        Risk assessment             │
        │     Risk prevention / reduction    │
        │        Coping strategies           │
        └───────────────────────────────────┘
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        ┌───────────────────────────────────┐
        │        Post-test counselling       │
        └───────────────────────────────────┘
            ⇙                        ⇘
┌──────────────────────┐   ┌──────────────────────────┐
│   HIV Negative:       │   │      HIV Positive:        │
│    News given         │   │       News given          │
│ Risk reduction        │   │    Emotional support      │
│   reinforced          │   │ Discussion about          │
│ Discussion about      │   │   disclosure              │
│ disclosure of         │   │ Discussion about onward   │
│ HIV status            │   │   referral                │
│                       │   │   HIV prevention          │
└──────────────────────┘   └──────────────────────────┘
            ⇩                        ⇩
┌─────────────────────────────────────────────────────┐
│   Follow up counselling and support as required       │
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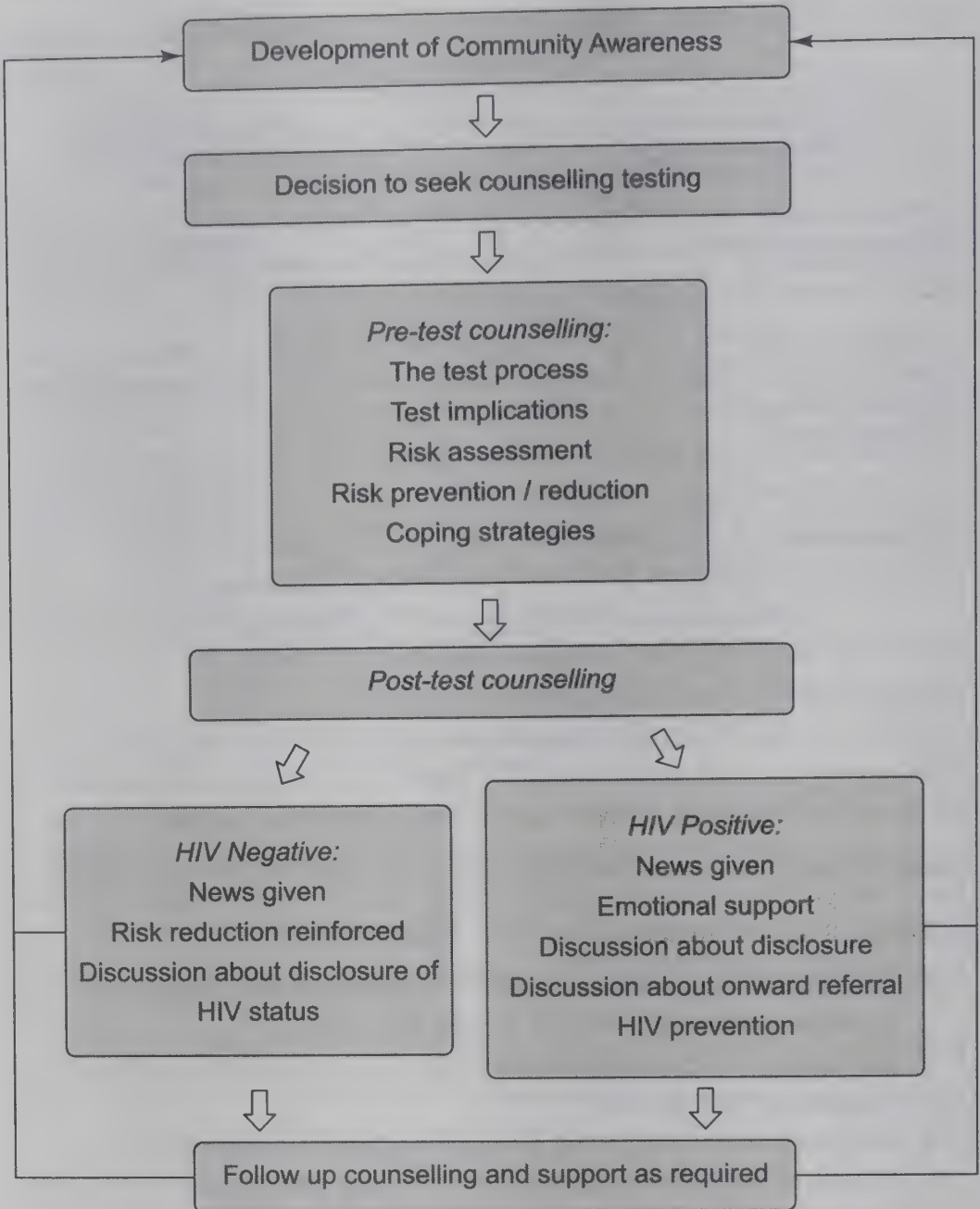
Figure 3.2 *Pre-test and post-test counselling*

During a post-test counselling session, when the result is positive, the counsellor:

- Communicates the result to the client, clearly and sensitively
- Responds to the immediate emotional needs of the client
- Encourages clients to disclose test results to their partner

or anyone else they trust, and offers support for the same. However, it is the client who decides whether or not to disclose, and to whom and when
- Encourages the client to review the risk reduction plan
- Offers information about referral services for both medical care and other forms of support

When the test result is negative, the counsellor:
- Encourages clients to stay HIV negative by adopting safer sex methods, including condom use
- Explores whether or not the client is in the window period (that is within 4-6 weeks of exposure to the virus). If so, the counsellor encourages such clients to seek a repeat test after three months

All clients are encouraged to return for follow-up support as and when they need (NIMHANS 2000).

VCTCs in Karnataka State

Karnataka State AIDS Prevention Society (KSAPS) has rapidly expanded the VCTC system in the state since the first centre opened in 1999. The number of centres increased from 34 centres in 2002 to more than 200 centres in 2006. It has also expanded from district hospitals to taluk hospitals, and more recently to PHCs in many districts of the state (NIMHANS Report 2006).

Programme guidelines require that each VCTC be staffed with two counsellors, one laboratory technician and a medical officer. Typically, the medical officer is a government employee given the additional charge of managing the VCTC, while the recruitment of counsellors is 'outsourced' to an NGO with longstanding experience in HIV-related work. Medical officers are responsible for providing leadership to the VCTC team, monitoring tests conducted by the laboratory technician, signing the test result forms, ensuring adherence to NACO policies on VCTC procedures by all, including hospital staff, and intervening in instances of discrimination against positive persons.

Counsellors' responsibilities involve conducting pre-test, post-test and follow-up counselling for clients seeking services in VCTCs, making field visits twice a week to publicise VCTC services by visiting NGOs and government health institutions

in the district, maintaining registers related to counselling, and sending regular monthly reports to KSAPS.

Everyday VCTC procedures

Typically, a client visiting the VCTC meets the male or female counsellor for a pre-test counselling session. Counsellors are trained to counsel both men and women, because matching the gender of counsellor and client is not always possible, especially on days when the number of visitors is large.

In an effort to maintain confidentiality, the counsellor first assigns a unique patient identification (PID) number to each client. The counsellor then enters this number in the PID register along with the client's name and address. Clients are subsequently referred to only by their PID number in other registers and test requisition forms. The client then undergoes pre-test counselling, at the end of which the counsellor seeks his/her consent to undergo an HIV test. If the client agrees, he/she signs an HIV test consent form. Then the counsellor writes down the PID number in the HIV test requisition form.

The client, with the test requisition form, goes to the laboratory, where the technician draws a blood sample and labels it with the client's PID number. The technician waits to pool together samples till about lunch-time. After lunch, he/she conducts the test on all samples collected in the morning and hands over the test results to the counsellor by about three in the afternoon when clients return for their post-test counselling session. Clients who undergo pre-test counselling in the afternoon return the next morning for post-test counselling. At no point during this process is the client required to meet or talk to anyone apart from the counsellor in the VCTC. Only the counsellors have access to confidential details about the clients.

Data Sources and Methods

Data for this paper comes from a mixed method evaluation of a capacity-building initiative for VCTC counsellors, designed and implemented by NIMHANS Regional Centre for Training in HIV/AIDS Counselling in collaboration with the Karnataka State AIDS Control Society (KSAPS), and funding support from the India–Canada HIV/AIDS Project (ICHAP).

The evaluation was carried out in three phases. During the first phase, baseline needs assessment was conducted from March to May 2003. During this period, project staff visited a sample of eight VCTCs and conducted in-depth interviews with all VCTC team members to help understand the challenges of implementing policies on the ground, the kind of support counsellors expected from their supervisors, and systemic constraints affecting service delivery in VCTCs. In-depth interviews followed a pre-determined interview guide.

During these visits to the VCTCs, an observation checklist was used to collect data about the location of the centres, besides ease of access and availability of basic infrastructure. The second phase of process monitoring, from March 2003 to February 2005, involved documenting the process of project implementation in terms of constraints, how they were addressed, and with what effect. In the final evaluation phase in March 2005, 71 counsellors underwent an end-line assessment of their knowledge, attitudes and skills.

Data for this paper is drawn primarily from the baseline needs assessment as well as from process monitoring phases of the evaluation, which included observations, proceedings and interactions with counsellors during training programmes and regional bi-monthly meetings.[1] All narrative data were read through for emerging themes, and coded and analysed in the software Atlas/ti.

Counsellors' Profiles

Fifty-seven VCTC counsellors filled in the baseline needs assessment forms, of which nearly an equal numbers were male (n=30, 53%) and female (n=27, 47%).

- The average age of a counsellor was 28 years, while the modal age was 25

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[1] The first author was a doctoral student in the Department of Health Education who worked on the monitoring and evaluation component of the project for her doctoral thesis. With the second author's technical guidance she designed and developed the evaluation design and was involved in all aspects of data collection and analyses. The second author was the project coordinator and was technically and administratively responsible for all aspects of the project design and implementation.

- 54 of the 57 counsellors held graduate degrees and 33 had post-graduate qualifications
- Social work was the dominant discipline among the counsellors, with 37 counsellors having a bachelor's or master's degree in social work (BSW, MSW).

Social work is not traditionally considered a very lucrative career. However, with the entry of international NGOs and bilateral agencies in implementation of HIV prevention and care programmes in the state, social work has gained visibility and become a viable career option. As a result of this increased demand for social workers, several social work schools have come up and social work education seems to be getting commercialised. Anecdotal evidence suggests that private schools of social work charge a hefty 'donation' from prospective students for admission to a degree course. Once they graduate students typically seek work in areas such as HIV, and with large international NGOs that pay well, in an effort to obtain 'returns on their investment'.

In this context, it was seen that the position of a VCTC counsellor was a fairly coveted one. It was viewed as a stable job as VCTCs had fixed routines and timings, and unlike in NGOs, counsellors were hardly ever required to stay back after working hours. It was also among the current well-paying jobs, particularly for those fresh out of college. Most importantly, there seemed to be an expectation among aspirants as well as existing counsellors that there was a possibility of this position becoming a 'permanent' one in the government. In fact, this expectation seemed to be an important reason why counsellors had not moved out of their jobs even though they faced serious problems at their workplace.
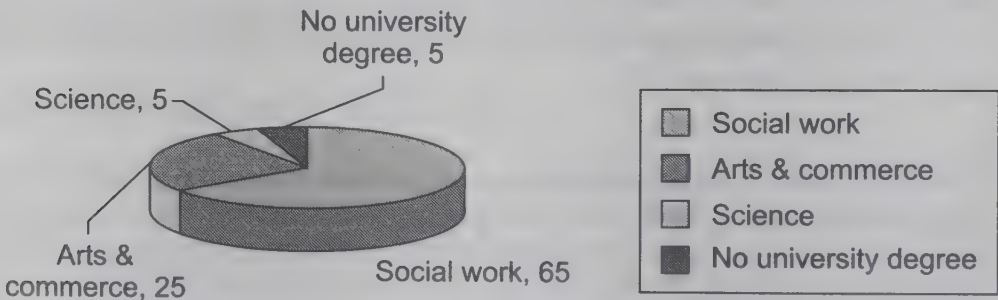

Figure 3.3 *Educational qualification (masters and bachelors degrees) of counsellors covered in the study*

During baseline needs assessment, when asked what they really liked about their job, many counsellors said they felt inspired by the fact that they were able to 'guide' people and 'solve their problems'. Many counsellors seemed to view their role in the broader context of psycho-social support:

> '...*I am not here to just provide HIV information, but help them to identify their strengths, weaknesses and giving them choices and alternatives...they will then make their own decisions...*'   — A female counsellor

When VCTCs were set up in August 2002, the recruiting agency shifted a cohort of trained counsellors from STD clinics to VCTCs, and later recruited additional counsellors from schools of social work.

Among the cohort from STD clinics, not many were post-graduates in social work. But they had received intensive training in HIV/AIDS issues and had undergone a diploma course in HIV/AIDS counselling. KSAPS decided to appoint them as counsellors with relevant experience in HIV were rare to find at the district level.

A few months later, the National AIDS Control Organisation (NACO) issued a directive that counsellors without a master's degree in social work or psychology be terminated. This generated considerable debate in KSAPS about the 'appropriate qualification' of counsellors, and caused a lot of concern among counsellors without social work education. NIMHANS Regional Centre staff believed that relevant experience and adequate training were far more critical than just social work education. Counsellors' background data also seemed to indicate the same (See Table 3.1).

Table 3.1 *Counsellors' experience and credentials in HIV/AIDS*

	MSW	BSW	Non-SW
% Counsellors with relevant experience (counselling, work with sex workers, in STD clinics)	46	23	65
% Counsellors with diploma in HIV/AIDS counselling	21	46	55
% Counsellors having work experience of one or more years at the time of joining VCTC	25	15	35

When these figures were shared with programme officers, they agreed that lack of 'appropriate' qualification seemed to have been compensated for by extended appropriate experience among those without social work education, and that terminating counsellors on the basis of their educational qualification alone was inappropriate. However, subsequent recruitment of HIV counsellors in the state strictly followed the National AIDS Control Organisation's (NACO) directive of restricting it to only those with a master's degree in social work and related disciplines. As this was a policy decision made by the central authority, KSAPS could do little to change it, even if there was state-level evidence that indicated that the decision was not entirely correct.

This debate had a fallout among counsellors as well. Observations of counsellors' interactions indicated that there were clear divisions along the lines of their education. Those without a social work degree became insecure and sought support from the recruitment agency with which they had continued their close ties. The recruitment agency supported these 'non-social work' counsellors to form a state-level counsellors' association. In spite of encouragement to all counsellors to join these associations, those with a social work degree were often reluctant to do so. This created tension between the two groups, which in turn made group decision-making and consensus-building much more challenging.

Dilemmas and Constraints Faced by Counsellors

A range of contextual and procedural issues in the district hospital created challenges for counsellors in performing their duties in VCTCs. The district hospital staff had not been sensitised to the idea of VCTCs and its procedures and the role of counsellors therein. Stigma and discrimination against those testing HIV positive was widespread, clients were unfamiliar with counselling process, and VCTCs had not been adequately linked to other support services. All these factors created hurdles for the counsellors and impacted the way counselling was practiced in VCTCs.

The District Health System: resenting the 'vertical' nature of HIV programmes

When VCTCs were set up in district hospitals, there was little involvement of the hospital staff and on their part they were reluctant to accommodate what they saw as an alien idea. Frequently, rooms allotted to the VCTCs were far from the OPD, were dark and dingy, or lacked privacy. When several district surgeons were consulted, they usually made it clear that they were not going to make any special efforts to accommodate VCTCs. Similarly, when KSAPS 'outsourced' the recruitment of counsellors to an NGO, it created a dual reporting system, which increased counsellors' alienation from their immediate environment. During visits to the eight baseline VCTCs, district surgeons raised this issue. 'How can these counsellors be accountable to us when they know that we do not pay their salaries?' asked one district surgeon.

Nominal charges (Rs10) collected in VCTCs were required to be deposited in a separate user fund operated by the medical officer and the district surgeon. But many hospitals resisted this, and insisted that the collections be deposited in the hospital user fund. 'Aren't you using our premises and facilities? Why should the VCTC have a separate user fund?' reasoned another district surgeon from one of the baseline VCTCs.

VCTCs were often thought of as a rented space with little relationship to other units within the hospital. And counsellors were perceived as 'outsiders' who could make no claims on the institution for any support.

Baseline assessment of adequacy of VCTC work space arrangements indicated that 20 per cent of the VCTCs did not have a separate space for counselling, 28 per cent had space that was very congested and lacked adequate ventilation, and 39 per cent reported that conversations with client could be heard outside because the partitions made for cubicles did not reach up to the roof.

Attitudes of clinicians and hospital staff towards counsellors

KSAPS personnel visited district hospitals in the process of identifying locations for setting up VCTCs, but could not conduct sensitisation programmes in all the district hospitals due to

limitations of time and personnel. Therefore, when VCTCs were established, district hospitals had little understanding of what VCTC services were or why they were being set up in district hospital. Further, high turnover of medical staff meant that sensitisation and training of hospital staff, especially the medical officers in charge of VCTCs, had to be an ongoing activity. This was not possible, considering that there was only one programme officer in KSAPS with the responsibility of running all VCTCs in the state.

Health professionals' unfamiliarity with counselling as a professional practice, coupled with the fact that counsellors were seen to be lower down the hierarchy because they were 'non-medical', contractual staff created several problems for counsellors, both within the VCTC team and with district hospital staff. For example, in one instance, the district surgeon ordered that counsellors sit in the OPD to allot numbers to OPD patients.

On the one hand, there was a lot of curiosity about what counsellors did, but at the same time there was disdain for their work. 'You only talk, and how can you help anyone by only talking,' was something counsellors frequently heard from their lab technician colleagues and district hospital staff.

Most medical officers seemed to view VCTC responsibility as one among many other responsibilities, and an additional burden. Some left all responsibility of running the VCTC to the counsellor, who then became accountable for anything that went wrong but without the powers to set things right. The few medical officers who were involved seemed to vie with the counsellors to prove that they were better counsellors. Clarifying who they were and what their role was, took up a lot of counsellors' time and energy. This affected their morale and interest, and led to feelings of burnout and inadequacy, which had a direct impact on the quality of counselling service.

Negotiating core ethical principles of VCTC: informed consent, confidentiality and non-discrimination

District hospital staff was unaware of VCTC procedures. The two main ethical pillars on which VCTC procedures rested, informed consent and confidentiality, were alien to the staff. Even though informed consent is supposed to be taken prior to

conducting several procedures, it is rarely seen as an individual right to decide whether or not they want some medical intervention. In the clinical context, it is reduced to a mere formality of putting one's signature on a form.

A study of the informed consent process in female sterilisation procedure in private and public hospitals in Chennai highlighted that women were not fully informed about the procedure, that they felt inhibited from seeking clarifications due to lack of rapport and the hierarchical nature of provider-client relations that reinforced the perception that the doctor knows best. Only about one-fifth of the women in the study reported reading and signing the consent form (Rajalakshmi 2007). Seeking informed consent for a HIV test was also seen in similar light.

The 'voluntary' component of VCT is a critical element. VCTCs were expected primarily to encourage those who felt they were at risk to voluntarily walk in to understand how to minimise their risk and get themselves tested. However, perhaps owing to the medical setting where VCTCs were based, most of the clients were 'referred' by doctors. Among these non-voluntary clients, there were genuine referrals of those who were symptomatic, and there were those sent for mandatory screening before a surgical procedure. Pre-surgical screening for HIV was widespread. When counsellors protested, the doctors responded, 'You have nothing to lose because you only talk. We are the ones at risk.' Even if counsellors refused to disclose the test results, clients were under compulsion to disclose the results in order to have the surgery. Initially, counsellors refused such requests, but soon found out that it was the client who suffered. Doctors asked clients to undergo HIV testing in private labs that charged up to Rs 300, which they could ill afford. So, counsellors had no choice but to acquiesce to mandatory HIV testing. Pre-surgical screening added considerably to counsellors' workload and took away their precious time, which otherwise would have been well-spent with more needy clients.

Maintaining confidentiality was also a problem. Staff friendly to the counsellors, not necessarily medical staff, frequently asked to know results of some particular client, usually in-patients. When counsellors refused to divulge information, the staff took it as a personal insult and stopped interacting with them. In a system that was not only hierarchical but also worked

predominantly on personal friendships and favours, counsellors felt increasingly isolated. Discrimination against clients testing HIV positive was widespread. In many hospitals, confidentiality was frequently breached. In-patients testing positive were discharged early with false assurances. Pregnant women testing HIV positive were refused delivery services even when there was a full-fledged PPTCT programme functioning in the hospital. In most of these instances of procedural violation, the medical officer did not intervene. Instead the counsellor, who was in a position of disadvantage as a non-medical professional and an on-contract employee, was often left to deal with it.

Programme officers' understanding of HIV counselling seemed to be at variance with counselling principles. They seemed to believe that an HIV counsellor should 'motivate and convince' clients to undergo HIV test. During review meetings, programme officers routinely asked counsellors what proportion of those who underwent pre-test counselling underwent HIV testing. This, they believed, was an indicator of counselling quality. This understanding, however, contradicted the principle of autonomy underlying HIV counselling practice, which privileges individual choice and the decision to undergo HIV testing. Counsellors were faced with an unrealistic demand — to 'motivate' increasing numbers of clients to undergo HIV testing, while also ensuring that clients' self-determination and autonomy was not compromised.[2]

Responses of clients to the counselling encounter

Clients' reactions to the counsellor and counselling process ranged from surprise to suspicion. Issues such as informed consent, confidentiality and privacy were rather alien to their experience in the clinical setting. They were used to being told what to do, but rarely were explanations provided or their preferences elicited.

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[2] With its recent ICTC guidelines, NACO seems to have further moved away from its own policy of HIV testing based on informed consent. These guidelines seek periodic assessment of counsellors on the basis of their caseload and their knowledge of HIV counsel''ng issues. It has also directed that counsellors' salaries be periodically revised based on their combined score of caseload and knowledge.

So when clients met a counsellor who actually took time to talk to them and explain and ask their opinion, some were pleasantly surprised. But many of them wondered why anyone would want to be so nice to them or what their motive was for behaving in this manner. The decision to test or not was something that seemed to have been already made for many clients. In case of clients seeking pre-surgical screening, they knew that if they did not get the tested, doctors would not operate upon them. So, the informed consent process was meaningless for these clients.

Similarly, for those who were symptomatic, HIV test was a clinical requirement and their volition was only secondary. And even when clients had a genuine opportunity to take their own decision about the HIV test, they were not sure what to do and frequently said, 'You should be telling us what to do and that is why we are here.'

Similarly, when a counsellor closed the cubicle door before the session, some clients, and in other instances their relatives, got flustered. 'What is the need to talk to the person alone behind closed doors?' was their question. Counsellors experienced difficulties explaining the concept of confidentiality, and that relatives could talk to the client later to find out what happened in the session but could not sit inside with the client. In a culture that privileges group decision-making over individual choice, especially where it involves women or children, dealing with disclosure was equally contentious. Counsellors had to frequently explain to their female clients' mothers-in-law, husbands and other male relatives that they could hand over the results only to the client herself and not to anyone else, however close they might be to the client. In some instances, relatives intervened on behalf of the client and said that he/she would not be able to deal with the trauma of a positive result and needs to be protected from it. In such a case, counsellors were in a quandary. What if they disclosed to the client and the latter did attempt to take the extreme step?

In one instance, a male client's family asked the counsellor not to disclose the test result, which was positive, to the client. The counsellor explained that she could not violate the procedure and disclosed the test results, emphasising that one can lead a normal life with some lifestyle changes even if one is HIV positive.

On receiving the test result, the client wandered off by himself, and his family was angry with the counsellor for not heeding to their advice. The client was later found sitting by himself in one of the empty wards in the hospital. This instance indicates a certain gap in counsellors' training and capacity to deal with the client's emotional response to the test result. On the other hand, it also highlights the dilemmas of the counsellor, and how they are required to think on their feet and constantly strike a balance between following procedures and responding to the needs of a particular client and his/her context.

Clients came from far and had to catch the bus back in the afternoon to their village. Amidst crowded OPDs and long queues, they had little time in which they had to have various tests done along with HIV, collect the reports and go back to see the doctor. So when clients were referred to the VCTC, it was with a combination of fatigue and resignation that they met the counsellor. This made it nearly impossible for counsellors to engage in a meaningful discussion with clients on key issues such as their risk perception and risk reduction. Many clients were too sick to even sit, making it difficult for counsellors to engage them in a detailed discussion about their risk behaviour. In such cases, counsellors had to merely explain HIV-related information and seek consent for testing. These conditions meant that post-test counselling sessions were also very stressful for the client and the counsellor. For example, if a client had denied any kind of risk in the pre-test session, communicating test results and helping the client to accept a positive test result in the post-test session was a particularly uphill task.

When counsellors eventually managed to develop a rapport, particularly with those testing positive, some counsellors developed an ongoing relationship with clients who would consult them in times of need. However, in many cases, widespread discrimination against such clients seriously compromised their relationship. Clients often felt angry and cheated, and lost faith in the counsellor. Further, the proportion of clients returning for follow-up visits was low, which created a dilemma for the counsellors — should they privilege providing emotional support over HIV information, or pack in as much information as they can so that even if the client does not return for follow-up visit, he/she has some basic information?

Counsellors tried to strike a balance, but were more inclined to providing information rather than respond to client's needs.

Talking about sexuality openly and explicitly was particularly difficult for female counsellors, many of whom were young and single. Being female, young and single was a social disqualifier to talk about sex. Female clients were curious as to how these counsellors knew so much before they were married. Male clients were less discreet about their curiosity and often asked the counsellors personal questions. In a small town where everyone knew everyone, female counsellors found it difficult to 'maintain their reputation' while being a 'good' counsellor.

Furthermore, service delivery procedures, whether in the VCTC or in PPTCT, had not been streamlined, which meant that caseload was erratic, waiting time long and certain basic facilities, such as waiting space, seating arrangement, drinking water, were inadequate. Counsellors reported instances where pregnant women fainted in queues waiting for their turn in the PPTCT centre. In such a situation, it was not surprising that HIV counselling was reduced, at best, to information provision.

VCTCs' poor linkages with other support services

VCTCs' referral linkages with clinical services, both within and outside district hospital, and with psycho-social support services were weak. Therefore, when a client tested positive, counsellors reported feeling inadequate to respond to some of the client's clinical, psycho-social and economic needs. This inadequacy, in part, stemmed from the fact that they were dealing with an infection that had 'no cure', and still having to deal with the client's expectation of tangible services like medicines and injections, typical in a clinical setting.

This feeling of inadequacy and having to constantly defend their role, and having no recourse to professional counselling supervision led to situations where counsellors began to seriously wonder whether their intervention was meaningful. 35 per cent of counsellors reported feelings of burnout during their tenure at the VCTC. And 65 per cent reported that they needed more support and inputs to enable them to continue their work and to feel satisfied with their job. In the absence of such validation and appreciation, many of them reported seeking it from their clients.

Concluding Comments

VCT and policies for VCTCs have originally been envisaged within a framework of human rights and ethical principles. However, there appeared to be significant gaps in the actualisation of these principles in the context of implementation of VCT in Karnataka. Stigma and discrimination were pervasive against those testing HIV positive, irrational testing was widespread, there was little understanding of counselling as a professional practice to prevent HIV, and awareness about VCT procedures and guidelines was low. It is in this overarching context that HIV counsellors in VCTCs found themselves working through various dilemmas and conflicts.

In particular, the phenomenon of instituting VCTCs in predominantly clinical settings resulted in a large proportion of VCTC clients being non-voluntary, including those referred for diagnosis by providers. This influenced the way HIV counselling was practiced in VCTCs. Counsellors often had to explain to clients why they were sent for HIV testing, and were under pressure to convince clients that the test was necessary. This, so to speak, turned the counselling process on its head and often left little time for counsellors to engage with the client on issues related to risk exploration and reduction, or fostering coping and support systems.

The general lack of supervision and support meant that counsellors had no way of seeking feedback on their counselling interventions and no one to turn to in times of professional crises or to validate their roles as professional counsellors. Lack of referral linkages with other clinical as well as psycho-social support services reinforced feelings of inadequacy that they 'only talk' and have nothing tangible to offer to their clients. There was no long-term policy for staff training and capacity-building. These issues often compromised counselling principles and client-counsellor relationships, and eroded counsellors' confidence, rendering them vulnerable to stress and burnout, and also devalued their professional identity.[3]

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[3] The supportive supervision system developed by the Department of Health Education, NIMHANS as part of its capacity-building programme addressed some of these issues, particularly related to professional development and supervisory support on counselling issues. However, administrative issues were beyond its purview and largely remained unaddressed till the end of the project.

Since the conclusion of our study, two further policy developments have taken place that have implications for the challenges and dilemmas faced by counsellors in Karnataka. In 2004, UNAIDS/WHO released a revised HIV testing policy statement (UNAIDS/WHO 2004). While recognising that HIV testing and counselling played a 'pivotal role both in treatment and in prevention', and that stigma and discrimination were responsible for low uptake of testing services, it made a case for alternative models of HIV testing apart from the VCT. One was provider-initiated testing, where health care providers routinely offered HIV testing to all clients in certain settings — STI clinics, antenatal clinics, and in areas with high HIV prevalence. The other was initiation of diagnostic HIV testing in persons with signs or symptoms of HIV-related illnesses, in order to aid clinical diagnosis and management. The statement also emphasised on the 'three Cs' in all models of testing — that testing has to be done only after seeking informed voluntary 'consent', has to be accompanied by 'counselling' and test results should remain 'confidential' (UNAIDS/WHO 2004).

This signalled a marked shift in HIV testing policy in India as well. While continuing to stress on the importance of counselling and associated ethical principles of informed consent and confidentiality, NACO, in its 2007 guidelines, introduced targets for counsellors. These targets were derived by estimating the percentage of people at risk in the 'general' and 'high risk population'. Notwithstanding previous public health experience with counter-productive 'targets', counsellors were urged to meet these targets, and their salaries were linked to achievement of the targets (NACO 2007). This has raised a major challenge concerning the very nature and quality of counselling as practiced in VCTCs. In the context of VCTCs, which have a heavy caseload, poor follow-up and little time for each client, counselling is becoming a misnomer for provision of information. This could seriously compromise primary prevention efforts, one of the core functional areas of a VCTC.

These changes in policy seem to have been the proverbial last straw for counsellors. Anecdotal reports indicate that counsellors in Karnataka are in the process of creating their own union. Counsellors in Karnataka and some of the other HIV high prevalence states collectively boycotted the most

recent assessment exam conducted by the State AIDS Societies under NACO's directive, in protest against its policy of linking their performance (achievement of targets) to salaries. Furthermore, counsellors resent their status as contractual employees and are agitating to be made 'permanent'.

In the current scenario, the HIV testing programme in the state could be facing a major crisis. The State AIDS Control Society could dismiss all counsellors and appoint new ones. But that would be very expensive. Perhaps a more reasonable response would be to have a dialogue with counsellors and develop a comprehensive personnel policy ensuring a supportive environment conducive to professional development. The dialogue could also be used to clearly spell out a recruitment, assessment and discontinuation policy. There is an immediate need to act before the window of opportunity shuts.

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PART II DOCTORS: VEXED RELATIONSHIPS WITH THE PUBLIC GOOD

Chapter 4

Public Sector Doctors in an Era of Commercialisation

Reflections from Senior AIIMS Doctors

Rama V Baru

In an era of growing commercialisation of health services, there has been considerable interest in studying the structure and dynamics of the private sector. An aspect that has not received attention is how commercialisation has influenced and shaped the behaviour of public institutions. Based on an in-depth study of doctors in a premier public hospital in Delhi, this paper examines the broad trends in the process of commercialisation, and its implications for values and aspirations of service providers.

The first part of the paper analyses the extent and nature of deep political and socio-economic changes, and their reflection on the patterns of provisioning and utilisation in the public sector. This analysis is based on research studies and relevant reports. The second part draws upon the findings of a study that was based on in-depth qualitative interviews with 15 senior doctors, who had retired from the All India Institute of Medical Sciences (AIIMS) in Delhi and presently were employed in a 'non-profit' private hospital. Topics addressed in the interviews included the doctors' social background, education and reasons for joining the public sector; their values, aspirations and expectations; the work culture of the hospital; and how things have changed over time. They were also asked about possible reasons for the changes, if any.

In this paper, I have particularly focused on themes around the interplay between structural and personal elements, including perceptions of how commercialisation of health

services has an effect on the values, aspirations, expectations of public sector doctors, and the work culture in public sector health institutes. I have also focused on perceptions regarding the strengths and weaknesses of the public and private sectors.

These interviews were conducted after seeking individual permission from the doctors and the chief executive officer of the hospital in which they were employed. The rationale for choosing doctors from AIIMS was that it is a premier teaching institution that has autonomous status. It is well funded as compared to other public hospitals, and private practice is not allowed. Therefore, it has all the attributes of an 'ideal' public institution. The in-depth interviews with senior doctors capture the changes in the work culture of this institution, and the reasons for these changes.

Deep Factors Shaping Health Services

Health researchers and activists have evinced considerable interest in shifts between public and private health care provisioning in India, mainly in the context of concerns about the rising disparities in access, and the rising cost of care.[1] Macro data surveys like the National Sample Survey and National Family Health Survey have noted inequalities in utilisation across out-patient and in-patient services, states, rural-urban and income groups, as well as shifts in utilisation from public to private sectors.

Researchers have also tried to analyse the reasons for the shift in utilisation from public to private health services (Baru and Kurien 2004). Several studies have explored the influence of 'proximal' factors, which include poor infrastructural facilities, lack of adequate human resources and shortage of supplies. These are acknowledged as significant reasons for lack of

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[1] Analysis of the National Sample Survey by Krishnan (1999), Baru (1999), and Sen et al. (2002) showed the variation in utilisation patterns across out-patient/in-patient services; rural/urban; states and income groups. Sen et al.'s analysis of the 42nd and 52nd rounds shows the shift in utilisation patterns over a decade, and also points to the rise in cost of services in both sectors (2002).

effectiveness of public institutions, leading to fairly high levels of dependence on private provisioning.[2]

This analysis only partly captures the factors determining the poor quality of public services, and does not address deeper or distal factors reflecting the socio-political forces that shape health service development. Distal factors include the extent of public commitment to health and the importance it receives from the political class; the place that it enjoys within 'rights' discourses; the level of engagement of critical social classes, such as the middle class, with public services; and the phenomenon of increasing commercialisation within and outside the public services.

Not a welfare state?

When compared to classical examples of welfare states as they exist in Western Europe, it is evident that the Indian polity does not fulfill some of the basic criteria which define a welfare state (Jayal 1999). According to Jayal, the European welfare state was inspired by the need to provide corrective measures for the socio-economic inequalities of market economies. However, in the Indian context, welfare interventions were seen as assisting state-directed capitalist development. It was imagined that state-led capitalist development itself would promote equity, and welfare interventions would perform a supplementary role.

This was different from advanced capitalist countries, where the roles of the market and welfare services were separate, and the latter's role would be to compensate and mitigate the inequalities intrinsic to market economies. I would agree with Jayal's argument that India can best be described as a 'developmentalist' state, with limited welfarism (Jayal 1999).

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[2] For a review of studies on the inadequacies of public provisioning, see Baru and Kurien (2004) 'Towards an Expanded Conceptualisation of Quality in Public Health' unpublished paper, JNU. This paper reviews the evidence from published and unpublished studies and argues that quality of services is an outcome of the interaction of tangible (that includes infrastructure, human resources,materials) and intangible (attitude and behaviour of providers; trust and commitment to the institution and patients) dimensions. Therefore both these must be studied as an interactive process rather than analysing them independent of each other.

This conceptualisation is useful in separating the socialist rhetoric, which is often repeated in policy documents, from the priorities and patterns of actual health service development. It also helps in assessing the extent to which the discourse on rights has played a role in shaping welfare agenda in the country.

Close examination of government documents on health and social services shows that a top-down programmatic approach to the design of interventions dominates. There is lack of a coherent vision that integrates poverty alleviation, health and education. Instead, the government is seen intervening in areas that are likely to enhance economic growth. The vision of citizen's rights as informing welfare interventions does not get reflected in these documents.

During the first three decades after independence, government documents do not explicitly acknowledge the role of commercial interests. But a closer examination reveals that the relationship between the state and market in the Indian health sector has been a dialectical one, with each influencing the other's role over a period of time. As a result, these two sectors became interrelated through many complex pathways. These include subsidised medical education, reliance on private pharmaceutical companies for drug supply, subsidies to private entrepreneurs, allowing private practice by medical and paramedical workers within the public sector, and levying user charges in government hospitals (Baru 1998).

Hence, in the case of health services, it would probably be more appropriate to characterise India as following a mixed economy model rather than a statist model, which would explain the structural and functional constraints health services face today.[3] The mixed economy model can be characterised by the coexistence of both market and state in varying proportions. In India, it has meant that while commercial interests grow, the role of the state becomes weak, which is reflected in ineffective public services, and a large, unregulated private sector.

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[3] The negative impact of the accommodation of commercial interests and on public provisioning was debated in Britain at the time of the creation of the NHS and these are extremely relevant when studying the consequences of commercialisation on public institutions.

There are very few studies that have analysed the emergence of the middle class in India, and the important role it has played in building public institutions. The available evidence from the post independence period suggests that the 'voice' of both the middle and working classes in demanding a strong and effective welfare state, which would embody the values of equity and universality, was weak (Baru; Nundy 2008). Therefore, the necessary and sufficient social conditions for the creation of the welfare state were articulated neither by the national bourgeoisie nor by the organised working class. This could be an important reason why there has been little demand for a strong welfare state, and the lack of active resistance when it was being eroded, and in some instances, even dismantled.

Middle class aspirations

Any serious analysis of the sociology of public enterprises requires addressing the role of the middle classes in the post independent period.[4] The scholarship on the characteristics of the middle class in India has not received the attention that it deserves. B B Mishra's study of the middle classes makes a distinction between the old and new middle classes in India.

He argues that the old middle class was propertied and had access to professional education that facilitated their entry into the bureaucracy and public institutions (Mishra 1961). The new middle classes, on the other hand, were not necessarily propertied, but had gained status through their ability to access higher education during the Nehruvian era (Khilnani 2004). During this era of India's development, state investment in higher education created a professional, managerial class that found employment in the public and private sectors, and constitutes the bulk of the new middle class (Deshpande 2003).

Majority of the doctors belong to the new middle class and, until the mid 1970s, were employed mostly in public sector institutions. It is only with increasing commercialisation of medical care that a significant proportion of doctors chose to work in the private sector. Those who spent most of their career

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[4] The characterisation of the middle class in terms of the old and new is derived from C W Mills' writing on the American middle classes (1956).

in the public sector were, as Upadhya observes, 'imbued with ideologies of nationalism and state-led development, but the demands of autarchic economic development meant that they had to be content with somewhat austere lifestyles, which were justified by the ideal of 'high thinking, simple living' (Upadhya 2008 P:59).

The opening up of the economy during the mid 1980s brought about considerable changes in the consumption patterns within the middle classes, which reflected itself in changing notions of status, and influenced values and aspirations (Baru 2005). Deshpande and Mankekar have both commented on the redefinition of the consumption patterns of the middle classes during the post 1980s, and observe that the ideal of austerity during the Nehruvian era was being replaced by conspicuous consumption and changed lifestyles (Deshpande 2003; Mankekar 1999). These changes in consumption patterns and lifestyles started creating newer demands, expectations and aspirations among the middle classes. Since doctors belong mostly to the middle class, their aspirations and values reflect the manner in which this class has undergone social transformation during the last two decades.

Studies on the social background of doctors before independence reveal that most of them either belonged to the old middle class or upper middle class and caste (Jeffery 1988). However, by the 1970s, the social background of doctors presented a much more mixed background, especially with affirmative policies for marginalised sections. In addition, the growth of private medical colleges in the western and southern states resulted in large sections of the new middle class gaining access to medical education. Typically, one saw the rise of middle castes that had acquired wealth through agriculture or petty trade, investing in medical and other professional education in the private sector.[5] Given the high fee structure, most of these doctors either go abroad or set up hospitals in the private sector.

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[5] This has been observed in S Vijaya's study of the changes in the handloom industry in Karur, Tamil Nadu. The Gounders and Mudaliars who have their base in agriculture and small industry are investing in their children's education (mostly sons) in medicine, engineering and business administration thereby challenging the Chettiars who were the powerful trading community in the area.

The higher salaries and easier working conditions of doctors in private hospitals presented a clear contrast to their overworked and comparatively less well-paid counterparts in public hospitals.

Growing commercialisation

The growth of the large private hospital sector is a phenomenon of the mid 1980s, and was supported with public subsidies in the form of concessional land, reduction of import duties on high-end medical technology, and tax exemption for research activities. Several national and regional business groups invested in corporate hospitals with the involvement of non-resident Indian (NRI) doctors from the United States (Baru 1998). The rise of these large hospitals altered the dynamics within the private sector and resulted in a considerable amount of competition, and also pushed up the cost of medical treatment during the 90s. These hospitals positioned themselves to attract the middle and upper middle classes, who were disillusioned by the services in the public sector and had exited from utilising them wherever the private sector was available (Baru 1998). Over time, these hospitals have redefined what constitutes good quality care, and how more money means better care, which, as Lefebvre rightly observes, 'echoes some of the values attached to consumerism and the Indian middle class' (Lefebvre 2008).

Given the intrinsic weakness of public provisioning, the space for accommodation and the entrenchment of commercial interests, both within and outside the health services, have been further enlarged. Apart from this, rent seeking behaviour of medical and paramedical professionals within the public health services over the last six decades has also contributed to the decline in its quality. The rent seeking behaviour takes many forms, and includes private practice by government doctors in clinics, public sector doctors acting as consultants to several private nursing homes, and in some states, promoting their partners in running nursing homes (Baru 1998). As a result of all these developments, there is a mixed economy in the provisioning of health services through the accommodation of private interests within the public services, and other areas like

financing, provisioning, drugs, technology and medical/paramedical education. This has led to distortions within the public sector, and has profoundly influenced the culture and quality of medical practice in both public and private institutions.

Interplay of Structural and Personal Factors

This section examines this critical area of the interplay between structural and personal factors, including attitudes, beliefs, values and aspirations of medical practitioners. Most studies on the public and private sectors have focused mainly on structural aspects, while scant attention has been paid to processes through which commercial interests, both within and outside the public health services, have affected values and aspirations of public service doctors.

The themes presented in the following paragraphs (drawn from in-depth interviews with AIIMS doctors) link changes in their ideals and cultures with the deep structural reasons for these changes. Economic transformations, and the rise of the new middle class with its attendant changes in lifestyles, have significantly redefined aspiration and values of the middle classes. Doctors belong mostly to the middle classes, and structural changes have demonstrably influenced their personal attributes, and their attitudes towards status and work in public institutions.

The interviews with senior doctors help capture the key changes in the social history and culture of this institution over the last five decades, by covering a range of issues like its evolution, work culture, organisational strength and weaknesses, growth of commercial medical services, and how all these factors have influenced the values and aspirations of its providers over a period of time.

A narrative of decline: ideals and infrastructure

Until the late 1960s, there was a tremendous drive towards institution building as a part of the larger project of modernisation and industrialisation of the economy and society. During this period, there was an effort to build institutions that

would attract the best minds, and would provide leadership to a range of institutions across the country. The state provided leadership by investing in higher education and setting up premier institutions like AIIMS for teaching and research. These institutions symbolised self-reliance, and could attract and retain the best scientists in the country. As a senior professor observed:

> *AIIMS was set up with the goal of producing medical practitioners of the highest order. While research and training was the primary focus, patient care was also given importance. It was a young institution when I joined it, and was on the rise in initial and middle years, and earlier part of the later years (early 1980s). However, during the later years, AIIMS saw a gradual decline with steady devaluation in the work environment. Commitment to work went down, and so did excellence in work. (30 July 2003)*

The work culture of the institute up to the late 1970s was captured vividly by the same respondent as follows:

> *The institute was infrastructurally superior to any other in the country. It provided a great deal of academic freedom and admissions to the post graduate courses were based purely on merit. It provided an opportunity to get into a group of likeminded people...the first thing that struck me about the institute was that it had so many academic people with an open mind for research who were well known in their areas. As a young doctor it felt great to be able to exchange ideas with them which were important for academic and personal growth.*

The reputation of being a centre of excellence for clinical practice and academic research was an important reason for doctors to work in the institute, although the remuneration was much lower than the private sector. This sentiment was voiced by a senior doctor, who observed:

> *I was not motivated by money. I think this was true for most doctors of my generation. Probably, this was an individual characteristic which was seen in most*

doctors at the institute. I was motivated by the desire to gain name and fame. Being the premier institute of the country, the most difficult of cases, the most variety of cases came there which you won't find anywhere else in any other hospital. So, you had the opportunity to continue to learn and to grow...to see medicine in its full spectrum. That's something outstanding about AIIMS. (5 November 2003)

By the mid 1960s, the institute was expanding, and with expansion came a number of challenges. Several of the doctors who were interviewed used the term 'we feeling' to signify the deep sense of belonging to the initial recruits, who constituted a small but closely-knit social group. This group derived a strong sense of identity as employees of AIIMS. As newer doctors and paramedical personnel were recruited, the numbers increased and the 'we feeling' was gradually replaced with greater anonymity.

With the growth in numbers, the institution started facing organisational problems in the areas of recruitment and promotional avenues for personnel, and also as a result of political interference in the functioning of the institute. Several mid career doctors experienced frustration and loss of motivation as a result of lack of promotional avenues. There was also a dramatic increase in patient load as a consequence of the near collapse of referral systems, which stretched the existing infrastructural and human resources and adversely affected the quality of care, it reported.

The institute lost its referral character and started performing the role of a general hospital. Since public institutions cannot refuse patients, doctors were just about coping with the increased patient loads. I felt harassed by the lack of adequate facilities and sheer patient load which started telling on the quality of care that I could give. I felt tremendous fatigue and this I believe started telling on clinical judgement and interaction with patients. (28 August 2003)

Competition with the private sector: lifestyles and markets

Apart from these internal challenges, the major external challenge cited by the doctors was the growth of commercial medicine at the tertiary levels of care, which coincided with the rise of the new middle class, consumerism and economic liberalisation. The newer recruits to the institute may have consisted largely of doctors who belonged to the emerging 'new middle class' of post-independence India, whose values were at variance from those of the earlier generation, strongly influenced by the nationalist struggle and the task of institution building. When the expansion of the institute took place, doctors who were trained in other institutes were recruited, and with it, the sense of unity and 'we feeling' gradually eroded. A senior professor observed:

> *Doctors from outside could not be held solely responsible for the erosion...it was more a reflection of the devaluation of social and moral values of society in general. The aims of the doctors had changed, rather than thinking of the overall good of the institution, the 'self' became their focus. In the early phase the 'self' was subordinated to the institution but later the self took over. Doctors wanted more for themselves (as did other professions) — visits abroad, more money, better lifestyle etc. (30 July 2003)*

Several doctors who were interviewed echoed these views, and saw the changes in the institute as reflecting the changes in society at large. A majority of the senior and mid career doctors cited growing commercialisation of medical care as an important marker for shifts in values and aspirations of government doctors. They articulated this in terms of the link between the rise of the new middle classes, increased consumerism and globalisation. These factors, they said, had far reaching consequences for changing values and aspirations of doctors. They were of the opinion that commercialisation of the tertiary hospital sector during the 1980s and 1990s challenged the hegemony that the institute and other such public institutions enjoyed in research, technology and clinical services. When government policy liberalised import of medical equipment in the 1980s, it led to the proliferation of private

hospitals that were able to get the latest in the market. This created direct competition between the public and private sectors. The difference between the 1970s and 1980s was vividly captured as follows:

> *In the early years, the private sector was not well developed, and all advances in technology and basic research were going on in AIIMS. But this changed during the 1980s when it became less expensive to import equipment and several hospitals acquired it. With this AIIMS lost its 'monopoly' and prestige that it once enjoyed...if anything we were thrown into competition with the private sector that had its own consequences. (4 November 2003)*

The consequences of this development resulted in stark differences between public and private institutions in terms of working conditions, salaries, patient load, infrastructure and access to technology. As a consequence, a section of those who were either looking for more money to keep up with the changing lifestyles, or were frustrated due to lack of promotional avenues within public institutions, sought to shift to private hospitals. It also resulted in questioning the role of the public sector, and comparing it unfavourably with the private sector. The shift in values and aspirations of doctors was seen as reflecting the changing aspirations and expectations of the middle classes during this period. As one of them articulated:

> *I see the rise of consumerism among the middle classes as an important reason for shift in values...society is wanting much more than before and doctors are not far behind this trend. The salary differential between the public and private sectors leads to unfair comparisons but that is the reality...in our time we had nothing to compare with because the public sector was the main employer...The huge salary differential resulted in glaring lifestyle differences...with the opening up of markets there was increased consumerism and this affected peoples' aspirations and expectations. (4 November 2003)*

The changing lifestyle of the new middle class had a profound

impact on how status was redefined, which resulted in a fundamental change regarding notions of success and what constituted a good life.

> *The world around was growing, India was growing and money was coming in a big way...younger doctors were comparing themselves with their counterparts in the business world. Those who had completed their masters in business administration were earning huge amounts of money...then they felt left out and wanted a similar lifestyle...the public sector salaries were not enough and this created dissatisfaction and frustration. Only a few could move to the private sector and those who stayed on in public services were constantly grappling with the discontent between what they earned and lifestyles that they aspired for. (5 November 2003)*

Despite these changes at the level of deep structure, it must be said that there are doctors who are committed to their research and patient care. They contrasted the work culture of public and private hospitals, and highlighted the positive attributes of the former to include job security, patterns of remuneration, consultative clinical decision making, the rational use of medical technology, choice of research, and the values of universality and equity. The culture of private hospitals was seen as being more individual driven, where each doctor attracts patients based solely on his or her clinical reputation. Given this scenario, there is very little scope for consultative decision making in private hospitals. Unlike other business concerns, where the organisation is bigger than the individual, in commercial medicine, it depends greatly on the reputation of individual doctors. A chief executive officer of a tertiary private hospital compared doctors with long years of clinical experience to 'branded consumer products', since it is the doctor's reputation that draws patients to the hospital rather than the name of the hospital. This is different from the case of, say, the hospitality industry, where it is the brand name of a hotel that draws people rather than its managers or other personnel. This is an important reason why senior doctors from reputed public hospitals are sought out by commercial institutions for building their credibility and reputation.

Conclusion

This study has shown that the structural changes in society get reflected at the institutional and individual levels, and play a crucial role in shaping attitudes, beliefs and values over a period of time. The responses of doctors reveal the complex interaction between class background, institutional and socio-economic factors that produce changes in values and aspirations. Their perceptions of major shifts in this process, interestingly, coincide with the three important eras of socio-political history of India-Nehruvian, post Nehruvian and the era of liberalisation.

During the Nehruvian period, the emphasis was on building self reliance and technical competence through state investments in economy, education and health. There was a drive towards building public institutions that would provide jobs to a large number of persons trained in medicine, engineering and related professions, who would form the new middle class in independent India. This new middle class did not consist of substantial property owners, as is the case with the old middle class, but the people who constituted this class derived their status and power from educational and cultural capital, and the professional careers that these promised (Misra 1961; Varma 1998).

With underinvestment in the public sector, the post Nehruvian period was characterised by growth of commercial enterprises in health, and the new middle class became the provider and largely the consumer of these services. However, the disenchantment with public provisioning among the middle classes set in by the early 1970s, and gradually, there was a distancing, even exit, of these sections from public provisioning. This was particularly marked in states where the commercial sector had grown and consolidated (Baru 2005).

Private practice by government doctors and their close involvement with the growing commercial enterprises saw the phenomenon of diversion of patients from the public to private. This process resulted in the monetarisation of the public sector and strengthened the perception that equated paying for care with better quality. With the gradual exit of the middle and upper middle sections from public provisioning, the voice for improving quality of public services was further weakened. The

disillusionment with public sector may also have provided the space for endorsing neoliberal solutions for commercialisation of health services. The voice for the public sector became weaker, with public hospitals increasingly being seen as a service for the poor who could not afford 'good quality' care in the private sector.

As discussed earlier, the differences in working conditions and salaries between the public and private sectors is likely to have led to a devaluation of the former, in the perceptions of both the doctors and the laity. This process of devaluation appears to have created frustrations among public sector doctors, and the resultant cynicism may often have an adverse effect on their attitudes to patients and the institutions in which they are employed. Thus, when rude behaviour by public personnel is often cited as reasons for avoiding the public sector, the reasons are not merely structural but also reflect broader processes of alienation of providers and users from the public sector. Over the last three decades, there has been a major onslaught on public institutions, which has had a marked impact on measurable structural elements, and, in equal measure, on social and perceptual processes at individual and institutional levels. These processes are hidden and cannot be measured in quantitative terms, but the demoralising of a public workforce, and what it does to effectiveness and quality of services needs to be acknowledged.

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Chapter 5

Working with Private Practitioners on a Public Health Intervention

The 'Key Clinics' Experience

Risha Hess, Saswati Sinha and Pritpal Marjara

D r Krishna's[1] *clinic is situated near the general bus stand of Koppal, a small town in Karnataka. He is a general practitioner and has been treating patients here for the past 15 years. The people living in and around his clinic have faith in his treatment. He keeps in touch with the medical fraternity, and likes to keep himself aware of clinical updates by occasionally attending the continuous medical education (CME) programmes organised by pharmaceutical companies in the neighbouring town of Shimoga. He is also aware of the growing human immunodeficiency virus (HIV) epidemic, and is interested in expanding his practice to address it.*

One day, a young man entered Dr. Krishna's clinic and introduced himself as Vijay, a professional working in the organisation Population Services International (PSI). With the doctor's permission, Vijay explained the link between sexually transmitted infections (STIs) and HIV, emphasised the importance of treating STIs effectively at the first visit of patients to the clinic, and introduced the Key Clinic Network's goal and methods of functioning. He also extended an invitation to Dr. Krishna to attend a technical update and then join the network, if he liked it.

The interaction with Vijay led Dr. Krishna to think about the many STI patients he had treated. He recalled one male patient who came to his clinic with sores on his genitals. On questioning, the patient had stated that he occasionally visited sex workers and generally wore a condom during intercourse, but not always.

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[1] Name has been changed.

Dr. Krishna diagnosed that case as a STI, but was not very sure whether it was syphilis, chancroid or herpes, so he advised some investigations and asked the patient to come back with reports. But the patient did not come back. Dr. Krishna remembered that case because the patient had been very worried and had asked him whether he had got HIV, and if it was the result of his recent paid sex encounter.

This case and many such similar ones where the patient had failed to turn up for follow-up now raised a lot of queries in Dr. Krishna's mind, to which he had no answers. He realised that though he had treated many STI patients to the best of his ability, unlike others, these patients seldom came back to his clinic. He had assumed that many of these patients had been cured. Dr. Krishna decided to accept the invitation of PSI as an opportunity to be updated on the management of STI cases more systematically. He attended the technical update. The participatory approach and the content of the training impressed him. He eagerly joined the Key Clinic Network as he could anticipate many advantages, such as increases in his patient load due to the programme's advertisements for the Key Clinics, an opportunity to share his experiences with his peers and colleagues who treated STIs, and to learn the latest and most updated treatment protocols.

Dr. Krishna now attends all the refresher updates and welcomes regular visits of young professionals from PSI to his clinic for discussing pertinent issues. Today, he not only treats STI patients, but also advises on condom use and partner treatment. He has confided to the programme staff that he is proud of doing his bit to prevent the spread of the HIV epidemic.

The private medical sector in India is complex, diverse and rapidly changing. This sector spans the large Max Health and Apollo Hospital chains that serve the upper class to the disparate and independent small clinics, sometimes housed in tents and manned by untrained quacks, scattered across the country to serve the poor. Any intervention aiming to work within this environment must understand this heterogeneity and its complex dynamics.

With the goal of harnessing the power of the private medical sector for public health aims, in 2004, Population Services International (PSI) created the Key Clinic Network of privately

practising allopathic doctors. The Network was instituted in 100 cities and towns, which had the highest HIV sero-prevalence rates and the highest density of commercial sex workers, in the high prevalence states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu. The aim was to assist private doctors to better treat and prevent sexually transmitted infections (STI) among their male patients. Over four years, PSI has learned many things about the struggles private doctors in India face, what works in motivating them to work towards public health goals, and also where the priorities diverge (or the environment is not supportive enough) to the point that public health goals cannot be achieved. This chapter outlines key lessons learned from the operation of a private sector medical network in India, as well as continuing challenges and successes.

Methodology

The Key Clinic statistics and findings of this case study come from a variety of PSI sources. PSI conducted several qualitative studies with Key Clinic doctors, including focus groups with 49 doctors between May and June 2006 and interviews with 18 doctors in August 2007. Additional data come from the monthly clinic visits and periodic trainings that PSI employees have with these doctors, from the experience of the authors during regular mentoring contacts with state based teams, and from training feedback forms and oral reports from PSI's franchise teams at monthly meetings. For information on actual practices of doctors, PSI conducted two simulated patients studies, in January 2006 and February 2007, through external research firms. The second round included a control group component.

Internal PSI records are kept of reported client load (gathered through telephone surveys and doctors' patient service logs) and demographic information. PSI conducted four rounds of quantitative knowledge, attitude and practice surveys with male clients of sex workers who reported having STI symptoms in the previous 12 months — April 2006 (n=1289), December 2006 (n=950), May 2007 (n=1220), September 2007 (n=1280) — which provide the information on patients cited. Finally, all three authors have worked for PSI on this project at some point, so

have working knowledge of the project. They should not, however, be considered impartial. Dr. Sinha was Franchise Performance Director overseeing all analysis and inputs into the Key Clinic franchise; Mr. Marjara was Research Director and Ms. Hess was Communication Director, overseeing the work done with potential patients. All three were based in Delhi and made frequent visits to project sites, where they observed activities and talked extensively to patients, doctors and PSI staff.

Social Franchising and the Key Clinics Initiative

A note on private social franchises

In social franchising, the 'franchisor' is typically a non-profit organisation that bears most of the financial risk involved in establishing franchised outlets. Operational support is provided by the franchisor, and typically involves access to commodities, supplies and equipment at reduced cost, in addition to training in clinical and business skills and advertising. In return, the franchisees (in this instance, private doctors) are often required to pay a franchise fee, maintain certain levels of quality standards, and record and report sales and service statistics. A key distinguishing feature of a social franchise is that the objective of the franchise is based on social, rather than business, motives (WHO 2007). The key benefits of a private social franchise include the ability to create quality services through private doctors who are often isolated, and the economies of scale achieved in training and advertising.[2]

Need for franchising private providers in STI care

Considerable evidence exists that private allopathic practitioners in India are important points of first access and providers of care to STI sufferers. The National AIDS Control Organisation's (NACO) 2000 Behavioural Surveillance Survey showed that nine out of 10 men with an STI who saw a doctor,

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[2] For more details on social franchises see, World Health Organization. Public policy and franchising reproductive health: current evidence and future directions guidance from a technical consultation meeting. Geneva, 2007.

sought allopathic treatment.[3] Half of them said they preferred to seek treatment from private clinics, compared with 40 per cent who preferred government hospitals. However, deficiencies have been widely reported in the care provided by these practitioners. The 2001 Health Care Provider Survey in Healthy Highway Project, India, which looked at practices of doctors in 12 cities in 11 Indian states, noted that private allopathic doctors do not manage STI cases effectively. Only 6 per cent of the allopathic doctors gave correct drugs in the right dosage, frequency and duration. STI patients were given advice on condom use by 43 per cent of doctors, and 13 per cent discussed partner treatment (FHI 2001). Four other studies found that the quality of case management, especially counselling, in STI clinics is inadequate and poor (Hawkes; Santhya 2002). One of these studies identified that in public and private health facilities in selected areas of Chennai, Tamil Nadu, only 10 per cent of the patients were satisfactorily managed with respect to the syndromic approach, which is recommended by the NACO; advice on condom use was given during only 30 per cent of the consultations, and advice on partner notification was given during only 27 per cent of the consultations (Mertens et al. 1998).

Most health care providers rely on laboratory tests for diagnosis of STIs. However, diagnosis of STIs is usually not straightforward, as the reliability of tests is limited (Dax 2007) and people are often infected with more than one STI at a time (WHO 1997; Holmes et al. 1997). Results are generally not available while the patient is still at the clinic, which means a missed opportunity for treatment if infection is found. And for lower income patients, lab tests are often not affordable. The syndromic approach offers a more affordable and standardised approach to diagnosing and treating patients with STIs.

Given the unquestionable importance of allopathic private

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[3] In India, a qualified allopath is one who has at least an MBBS (Bachelor of Medicine and Bachelor of Surgery) degree, and a registration number from the Medical Council of India. Doctors who do specialisation in a subject after completing their MBBS are called specialists in the respective subjects. Non-allopaths can be of two types, one are degree holders of alternative systems of medicine (Ayurveda, Homeopathy, Siddha, Unani), and the other with no degrees but providing health care on the basis of some self acquired knowledge and skill, with no formal training.

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providers who treat vast numbers of STI patients, but inadequately, training and franchising these service providers is likely to increase the availability of quality STI services.[4] This becomes vital in the light of the established fact that strengthened STI services are crucial to stem the progress of the HIV epidemic.

The structure of the Key Clinics initiative

PSI, with funding from 'Avahan: India AIDS Initiative of the Bill & Melinda Gates Foundation', launched the Key Clinic Network in 2004. It was deemed that a social franchise of privately practicing doctors would be an appropriate way to address the poor STI treatment scenario in India. PSI is working to reduce HIV incidence by treating and preventing STI[5] in male clients of female sex workers in 100 high priority towns in Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu. In addition to the work done with Key Clinic doctors, potential STI patients — men with a history of a high-risk exposure or with symptoms of STIs — are encouraged to seek treatment from Key Clinics via integrated mass media and on-ground communication activities. PSI focuses on patients in poorer socio-economic groups, and the doctors who serve them.

Key Clinic doctors are trained in the components of syndromic STI management and prevention through a curriculum developed by PSI in partnership with IntraHealth International, according to NACO's flowcharts and international best practices. Teams from PSI identify and recruit private medical practitioners, provide initial training and semi-annual refresher trainings as well as monthly support visits to reinforce compliance with syndromic management protocol. As part of this protocol, doctors are expected to provide risk reduction counselling, advice on condom use, and recommendations for the partners of STI patients to be treated.

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[4] While the project acknowledges the importance of non-allopathic providers as well, for legal reasons, we were not able to train them on prescriptions, so did not work with them.

[5] Apart from being serious diseases on their own, the presence of STIs can increase the risk of HIV infection and transmission by a factor of two to nine (Steen and Dallabetta 2004; Hayes, Schulz and Plummer 1995; Laga et al. 1993).

PROFILE OF KEY CLINIC PROVIDERS

- As of August 2007, there were 773 active Key Clinics in 95 towns.
- Located in high HIV prevalence areas with an active male STI client load.
- They treat a combined average of 9,000 male STI cases per month.
- The clinics tend to be small, independent, standalone offices, with one doctor and possibly a front desk person/assistant.
- Some have dispensaries in the clinic, but most have a chemist nearby that they send their patients to.
- Half are open seven days a week, and the remaining six days a week.
- Hours open per week

<20	4%
21-40	33%
41-60	48%
>60	15%

- Medical degrees

Only MBBS (general practitioner)	67%
Other diploma but no post graduation	7%
Post graduate degree in STI, skin or venereal disease (STI specialist)	11%
Other post graduate degree (other specialist)	15%

Members of the Key Clinic Network also receive syndromic management guidelines, record keeping tools, quarterly newsletters, periodic technical letters, ACT-1 kits for treatment of urethral discharge and painful scrotal swelling syndromes, and promotional items (Key Clinic branded clinic signs, directional signs, counselling aids and posters/brochures) to attract patients to their clinics. In return, the doctors are expected to follow the protocols for management of STI cases. The programme prioritised the tasks that constitute quality standards for syndromic management of STIs, presented in the form of a quality of care matrix. Doctors were oriented to these

standards and provided with the matrix in the form of a table mat for easy reference (Figure 5.1).

Figure 5.1 *Facsimile of Key Clinics brochure*

PSI promoted the syndromic approach, using standard flowcharts adapted to the local epidemiological profile, to help doctors decide on a treatment that would be effective against all the organisms most commonly known to cause the particular syndrome. This simple approach helps to ensure that the patients get effectively treated at the first contact with the health care system.

A Process of Growth and Adaptation

Convincing doctors to participate

In resource-poor countries, professional development opportunities can often be limited. As a result, doctors in these countries are usually excited to join a PSI franchise, and are willing to regularly attend trainings and meetings. In India, however, we observed the barriers to motivating doctors to join

to be twofold; first, many pharmaceutical companies conduct guest lectures to update doctors' knowledge, with exciting gifts and monetary support offered to attend conferences and events. This means that the franchise is not their only opportunity to learn and network with other doctors, and since PSI does not offer gifts comparable to the pharmaceutical companies, the task becomes difficult. The other barrier is that a system of renewal of doctors' registration based upon completion of a certain number of medical updates has yet to be established in many parts of India, including the programme states, so no 'credits' are gained by attending these sessions.

Due to the initial hesitancy of doctors to join, the programme provided initial training to the doctors before they decide to join the network. A qualitative study with Key Clinic doctors (PSI's Transfer of Learning Study) revealed that the participatory approach followed in the training was able to attract doctors to the programme. The doctors appreciated the discussions held in the training, in which they shared their experiences, assessed the application of knowledge in real situations, and demonstrated problem-solving approaches.

They also valued the demonstration and practice of steps of physical examination on real-sized torso models, and enjoyed role-plays to assess a client's risk and provide essential health messages with a positive attitude toward STI clients. A considerable proportion of doctors among those who attended the initial training opted to join the franchise and paid the membership fee.

In the year 2006-2007, an average of 66 per cent of doctors who attended training joined the network. It is worth noting that the average percentage of doctors who decided to join the network varied considerably among states (a common theme when trying to implement a programme across the culturally different regions/states of India). In 2006-2007, Andhra Pradesh had 87 per cent, Karnataka 62 per cent, Maharashtra 82 per cent, and Mumbai 90 per cent enrolment of doctors from the initial training, whereas Tamil Nadu had the lowest rates of enrolment (around 45 per cent of those initially trained), possibly because a number of other agencies implement HIV programmes with focus on care and support in Tamil Nadu.

The doctors expressed greater interest in learning new clinical

areas, such as HIV care and support, than in improving their skills in existing practice areas. In many cases, doctors insisted to PSI employees that they did not perceive problems with their current practices. Many doctors pointed out that the patients they treated did not return with the same complaint, citing this as proof of the effectiveness of their treatment. However, surveys with patients revealed variable levels of satisfaction with the care they received from doctors, and that many of them 'shop around' for treatment from different doctors. Patients reported taking an average of 2.5 actions per STI episode, which included going to a chemist, friend or various doctors (unpublished PSI STI Output Tracking Survey, September 2007).

The participatory methodologies used in training, and the choice given to doctors to join the franchise after training, were important in influencing the doctors to enrol for a public health cause. Though the health providers widely appreciated the training, they felt challenged by the need to change their services for STI patients, and often required additional motivation and persuasion to follow the recommended syndromic protocols.

A responsive strategy

Several small adjustments were found to increase the doctors' motivation to come to the initial and biannual refresher trainings. The quality of the initial training programme, the venue, and the agenda were all found to be important factors in keeping the private doctors motivated. Private providers are often reluctant to attend a long training course as this interferes with their ability to keep their clinics open during regular operating hours, which results in loss of clientele. PSI had to curtail the original two-day-long course to a three-hour training to accommodate this concern. Efforts were made to schedule the date and time of the training according to the doctors' availability, which meant that most training sessions took place in the afternoon on weekends.

The training differed from most programmes for medical personnel[6] and scientific sessions organised by pharmaceutical

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[6] For example, training courses on sexually transmitted diseases for the in-service medical personnel under the national STD control programme, training of medical practitioners in tuberculosis control programme, leprosy control programme, family planning and malaria control programmes.

companies (Agarwal et al. 2005) in two respects. First, the PSI training is not a one-time event. Refreshers are conducted every six months, and doctors are visited by staff members on technical aspects monthly. Second, unlike a fixed curriculum and manual for training, the programme continually revises and updates the curriculum, based on feedback received from the participants, to keep the training tailor-made for the participants.

To provide further encouragement to doctors in following the recommended protocols, the state training teams organised panel discussions in some cities, in which eminent local STI specialists shared their experiences and emphasised syndromic management with Key Clinic doctors. The enthusiastic participation of doctors indicated that they valued hearing from practising STI specialists. Additionally, teams realised the need and demand for improving clinical skills of Key Clinic doctors for diagnosis of STIs, and established linkages with STI departments of government medical colleges and hospitals to organise clinical practicum sessions for the doctors. These clinical sessions with real patients were conducted by senior STI specialists. Participant doctors' feedback indicated that they were very satisfied with these training opportunities.

After one and a half year of its implementation, the programme's research revealed that 70 per cent of STI cases were being treated by 30 per cent of the clinics in the network, and 100 towns of the programme area account for 65 per cent of total sex workers. As a result, the programme initiated a de-franchising process, and only those clinics were retained in the franchise that had the highest impact potential, which meant clinics with highest STI client load and located in the 100 towns identified. While de-franchising decreased the overall number of clinics in the network, the programme continued to recruit additional doctors to increase accessibility in areas where research and anecdotal information indicated unmet need.

Clearly, responding to health providers' concerns regarding training process and content is an important element to consider in designing training for private sector medical practitioners. Additionally, distinctiveness of the training programme and strategies such as endorsement of protocols by local renowned STI specialists proved useful in motivating doctors to put the

new learning into practice. Mid-project adjustments in the number of franchised doctors were also made to ensure that the maximum number of STI patients was served cost-effectively.

Simplifying doctors' choices in a complex market

After conducting a market assessment of drugs available for treating STIs, PSI realised that although it had appeared initially that patients and physicians in India do not have problems with access to pharmaceutical drugs, in fact, the situation was exactly the opposite. The proliferation of drugs available made the marketplace very confusing. Moreover, the drugs and doses required for proper STI treatment are often not easily accessible. While in countries like Uganda, Cameroon and Cambodia, PSI has pre-packaged treatment kits in parts to increase access, in India, they are necessary to ensure correct choice of dosing and duration of drugs. For instance, in 2003, when PSI conducted a market assessment (unpublished PSI Feasibility Study), there were over 88 versions of doxycycline in the market, in different doses (mg), packaging (number of tablets per strip or box), and even forms (capsules, tablets, dispersible tablets, syrups). Yet, no company distributed a package of 30 100mg tablets each (which would be the correct dose and duration for GUD treatment). In response to this complex market scenario, which had the potential to confuse doctors, chemists and patients, a team of public health experts and epidemiologists advised PSI to launch an STI kit for treating urethral discharge to simplify the prescription process for doctors, and to ensure that patients receive some information and prevention guidance regarding their STI.

In 2004, PSI launched ACT-1, a pre-packaged kit for urethral discharge and painful scrotal swelling. The kit contains 1g azithromycin, 400mg cefixime, condoms, partner treatment cards, and information for the patient and doctor. Acceptance of ACT-1 increased after PSI relaunched the kit in 2006. A major component of the relaunch was a price reduction from Rs 75 (plus taxes) to Rs 49 (including taxes). The reduction in price was welcomed by doctors, as it was perceived to be more affordable for their patients.

Successes and Failures

Influencing treatment practices

From a public health perspective, getting patients the best possible treatment, getting their partners treated as well, and motivating condom use are key to reducing STI prevalence. To better understand if the Key Clinic intervention was achieving these goals, monitoring approaches, such as patient service logs and self reported sample surveys, were considered. These methodologies were trialled for a year. PSI's doctor support teams reported that study results often did not correspond with their first hand observations of doctors' clinics, nor with the feedback received from patients.

There are two broad reasons for these. Private doctors in India are not required to report on patient details, and Key Clinic doctors were seldom motivated enough to keep records on the STI cases they saw. We discovered several instances of under-reporting of STI patients. We also found that in reporting what treatment was provided, many doctors listed the recommended treatment, but this did not correspond with their actual prescriptions. The conclusion is that provision of 'correct' (recommended) treatment was over-reported. Patient service logs between December 2006 and February 2007 revealed that 97 per cent of doctors reported using the correct drugs for treating urethral discharge, and 81 per cent used correct drugs for genital ulcer disease. Simulated patient study findings, however, show that only 65 per cent and 12 per cent prescribed correct drugs in the two cases during the same time period. Any programme using doctor-reported data in these settings should be aware of these problems in determining actual practices.

PSI developed a simulated patient approach to find out how Key Clinic doctors were actually treating patients. The simulated patient approach involved recruiting and training of men with specific symptomatic sexually transmitted infections at the time of the survey. They were sent to clinics and then asked about the interaction. Then, the prescriptions they were given were analysed. While many aspects were evaluated, including whether genital exams were conducted or history was taken, doctors were primarily assessed on four quality

indicators, identified as critical to effectively reduce disease prevalence:

- Correct treatment (drugs, dosage and duration) for urethral discharge (UD)
- Correct treatment (drugs, dosage and duration) for genital ulcer disease (GUD)
- Advice on partner treatment
- Encouragement of condom use

The first follow-up survey also included a control group of non-Key Clinic practitioners. The results are summarised in Table 5.1.

Table 5.1   *Comparison of practitioners' quality of care indicators over time*

	FHI Study 2001^	PSI Simulated Patient–Key Clinics		Statistical Difference between 2006 and 2007? (p<0.05)
		Jan 2006	Feb 2007	
Correct Treatment of UD	6%	36%	54%	Yes
Correct Treatment of GUD		5%	4%	No
Condom Counselling	43%	45%	53%	No
Partner Treatment Advice	13%	17%	39%	Yes

^ As this was done with different methodology and sampling, the results are not directly comparable but do provide a point of comparison.

Through these surveys, the programme saw a significant improvement in the skills of doctors in taking patient histories. During the physical examination, examination of penis, milking of urethra and retraction of foreskin — all important in making an accurate diagnosis — improved significantly, but the percentage of doctors who conducted an anal examination did not improve. Doctors cited that they performed anal examinations irregularly because they perceived that the patients would be reluctant to have their anal area inspected. It is likely that disclosure of anal intercourse is commonly avoided due to taboos around the practice of anal sex (Acharya 2002; Bourne 2006).

Comparing the findings from Key Clinics and those from non-Key Clinics (see Table 5.2) it was observed that three key

indicators — correct treatment for UD, advising partner treatment, advising condom use — were statistically significantly different between the Key Clinic and non-Key Clinic doctors.

Table 5.2 *Comparison of Quality of Care indicators between Key Clinics and non-Key Clinics, February 2007*

	Key Clinics^	Non-Key Clinics	Statistically Different? (p<0.05)
Correct Treatment of UD	58%	6%	Yes
Correct Treatment of GUD	2%	5%	No
Condom Counselling	50%	29%	Yes
Partner Treatment Advice	31%	3%	Yes

^ These numbers don't match those in Table 5.1 because the non-Key Clinics sample was unable to do an exact geographical match. So, the sample of Key Clinics was adjusted to match the two.

Understanding the varying success of the intervention

Changing behaviour of physicians is a complex issue. The programme has demonstrated improvement in providers' correct treatment of UD, and provision of partner treatment advice. There are no good industry benchmarks on how much behaviour change on prescription pattern or management style of a disease can be expected from health care providers. The working behaviour of professionals is subject to influences and dynamics that are different from lay practices such as condom or seatbelt use. While substantive behaviour change can be effected through the means of training and continued support, it is likely that external help (in the form of legislation, regulation, insurance, patient education and institutional support from the medical establishment) is required for changing particular aspects of practices (Smith 2000; Cohen 1994; Vickrey 2006).

Some reasons hypothesised for the success in increasing treatment of UD (particularly when treatment for GUD remained unchanged) are:

- The recommended treatment for UD includes simple oral antibiotics with no major or fatal side effects (unlike first-line treatment for GUD, which includes penicillin)
- The pre-packaged ACT-1 kit facilitated the use of correct treatment. In interviews, doctors reported satisfaction with

pre-packaged therapy for urethral discharge syndrome, and the highly subsidised price of the kit
- There are more reported UD patients than non-herpetic genital ulcer patients, which gives doctors more opportunities to treat, learn and retain the correct knowledge
- The simulated patient study methodology may not capture correct treatment of GUD[7]

In the area of treatment practices of doctors, it would seem that the public health community and private doctors would want the same thing — scientifically correct treatment. However, it is clear from the results of the simulated patient study that without the consistent and high quality interventions like the Key Clinics programme, the practice of recommended standardised treatment regimens is infrequent, even after the training interventions. Why? Several hypotheses exist, including that patients have decision making power that influences the doctors; that pharmaceutical companies exert pressure and incentives to prescribe medicines that aren't the best options; that doctors aren't convinced by the treatment protocols; or that they are unable to diagnose the ailment correctly to begin with.

Clearly, for those not in Key Clinics, basic knowledge of recommended treatments could be a barrier. However, for those who have received the trainings, scores on knowledge indicators in post tests have been high.

Concerns related to income may underlie these divergences, as we learnt from conversations with physicians. Doctors reported that their client load falls due to the increased number of doctors practicing in their areas. As a result, they focus on attracting patients. If patients prefer injections to other types of treatment, as doctors often reported to PSI staff, the doctors would acquiesce in order to please the patient (knowing that if he doesn't give the injection some other doctor will). Additionally,

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[7] As per ethical considerations of the Simulated Patient Study methodology, mystery patients were not to take any medicine/s or injection/s inside the clinic. In case the doctor intended to give injection/s to the patients, they refused to take that/those injection/s. As per the study guidelines, these mystery patients could not also ask the doctor about the name and other details of the injection to ensure doctor wasn't alerted to the 'mystery' client. Therefore, the Simulated Patient Studies may hot have accurately measured penicillin use by doctors.

if patients react negatively to requests for genital or anal exams, the doctors often do no insist — again, to retain the patient — thereby limiting their ability to correctly diagnose the disease. There is no formal research to validate or invalidate this hypothesis; however, during several interactions with the doctors by the field and training teams, this was the feedback that they received. The fear of anaphylaxis (a rare but fatal condition that can happen as a side-effect of injectable penicillin) was also cited by a number of doctors as the reason for non-adherence to recommended treatment for GUD (see box).

PROVIDERS' FEAR OF PENICILLIN

The recommended protocol for treatment of GUD includes injections of penicillin. PSI found that privately practicing doctors in the network were very hesitant to use penicillin for fear of patients experiencing anaphylactic shock. Fatal penicillin-induced anaphylaxis is quite rare, only occurring in about 0.002% of people given penicillin. The lack of penicillin use has even resulted in lack of availability. Without demand, the chemists have no incentive to stock it. Compounding the problem, the recommended test for allergies, a combination of penicilloyl-polylysine and benzylpenicillin, is not available in India.

Providers also stated that low retention of knowledge of the correct treatment of non-herpetic genital ulcer syndrome is due to the fact they see very few of these cases.

There are several other contextual factors which provided challenges to the programme:

- **Authority of doctors:** Doctors often hold a position of great respect, and they enter the profession expecting to receive enormous respect. Patients, in turn, expect doctors to be all-knowing and will not question them. This makes it difficult to question doctors' treatment practices, or to work with patient rights and patient education. PSI found doctors resistant to frank criticism or suggestions for improvement; often responding with 'I'm the doctor, I know what's best'.
- **Respect for elders:** As the PSI programme used young doctors as the trainers, they often had difficulty speaking

directly to the more experienced doctors. Added to the respect given to doctors, was that given to older people generally.

- **Saving face:** In spite of witnessing evidence that doctors were treating incorrectly, support teams sometimes found themselves unable to communicate this adequately to the doctors.

- **Doctors provide curative not preventative services:** It is widely expected that allopathic doctors cure problems, and social workers or others prevent them. Therefore, many doctors were uncomfortable, even unwilling, to do any counselling around risk reduction. However, their advice is often heard, because of the authority they embody.

These reasons, combined with the desire to see as many patients as possible and not spend too much time with an individual patient, contribute to the insignificant increase in counselling patients on condom use. Observations from Uganda and Tanzania (King et al. 1994; Martin et al. 2005) confirm that very low percentage of practitioners provide advice on condoms. It has been observed, however, that the two things doctors are most hesitant to do in relation to condoms is to conduct a demonstration of putting on a condom on a phallus model and talk about sexual acts with the patient.

'It takes time to demonstrate condom use on the model, and I cannot give so much time to one patient.' — a Key Clinic doctor

'I cannot keep the penis model on my table because my other (non STI) patients may mind.' — another Key Clinic doctor

When the task was repositioned as simply advising a patient to use a condom in every sexual act — especially while still infectious — and doctors were provided with job-aids to help explain this, the field and the training teams observed that the doctors seemed to accept this, and stopped questioning their role in advising condom use.

Finally, the reasons for success in increasing partner treatment advice are also two-fold. First, treating another patient increases a doctors' client load, the income from consultation and sales margins on dispensed medications, something that greatly motivated doctors. Second, partner treatment advice is not time or effort intensive; it simply involves writing a second prescription or asking the patient to bring their spouse along the next day.

FEEDBACK FROM DOCTORS

Suggestions for potential activities: The Key Clinic doctors unanimously wanted to continue the current trainings, and also suggested having a website for ready access and referral to information related to STIs, HIV and the programme, establishing links between Key Clinics and voluntary HIV counselling, and between testing centres and HIV treatment and care centres. Finally, they asked for sponsorship for attending conferences, similar to what pharmaceutical companies offer.

Learning methodologies: Doctors noted that the post-training support visits should include a more precise discussion of the purpose of the visit, in order to make these visits effective for transfer of learning.

Interest in HIV and AIDS topics: Key Clinic doctors were overwhelmingly interested in receiving updates in HIV care and treatment, including management of opportunistic infections.

Sharing research results with the doctors: The doctors appreciated the transparency the programme maintains in working with them. In particular, they demonstrated interest in knowing the simulated patient study results. They also appreciated the way results are shared with them, with no reference to any individual doctor's performance. They were very happy to see positive results, found the gaps distressing, and expressed desire to improve results on the quality of care indicators.

Conclusion

In planning and implementing a project that works through doctors, PSI had to take notice of the complexities and varying needs of medical practitioners. For instance, we found that while financial concerns are a top priority for privately practicing doctors, the most effective recruiting approach (that which predicted continued involvement in the network) was to appeal to their interest in helping address HIV and AIDS. The offer of training alone was often not considered initially appealing by the doctors, nor did it fulfill any mandatory continuing education

requirement in the states where the programme was implemented. However, in due course, and with exposure to the programme, when the doctors recognised that the content and methodology were unique and the training timings were convenient, they were eager to participate.

Things that *did* work included:

- High quality training, pre-training exposure, continued support mechanisms
- Adjustment in accordance with doctors' expressed needs — enhanced training support on popular topics such as HIV/ AIDS care, convenient timings, simplified pharmaceutical choices and user-friendly guidance for doctors
- Utilising key opinion leaders like medical specialists
- Aligning the programme with the doctors' financial concerns by optimising the time spent with patients and in training sessions
- Collectively involving the doctors in sharing the results and successes of the interventions

Beyond the financial considerations, there are barriers to easy implementation of a training programme, including:

- The authority and respect accorded to doctors and elders, and the difficulties in communicating their shortcomings to them
- The widely held idea that doctors cure and it's someone else's job to prevent
- The influence that patients exert on doctors' treatment practices
- Fear of administering penicillin, and the lack of supportive environment in this regard
- Lack of record keeping standards, and also the patients' practice of 'shopping around' for treatment of each ailment, making it difficult for the doctor to monitor treatment

Over time, Key Clinics were successful in improving the quality of STI care, including correct treatment of UD and increasing the proportion of doctors who advise STI patients to have their partners treated. This success is even more apparent when compared to similar doctors not included in the network. Unfortunately, across the board, treatment of STIs, especially GUD, remains poor, and more work needs to be done.

The answer to the question of what works to improve quality of

service of private health care practitioners in India is not simple. The experience of PSI suggests that multifaceted interventions for refreshing knowledge and skills, providing continuous support to help application of new learning, and adaptation to the changing needs of doctors are sound strategies. One-time, fixed curriculum training may affect knowledge, but does not necessarily result in behaviour change of doctors. In particular, assessment of quality of services at periodic intervals offers useful insight into performance gaps and offers guidance for future focus of the programme. Demand generation for treatment-seeking targets not only patients but increases the motivation of private doctors. Finally, it is important to note that strengthening of formal regulatory mechanisms for private doctors, such as mandatory reporting on patients and renewal of registration on successfully updating knowledge and skills, is essential and not substitutable (by social franchising or other voluntary interventions) as a means to ensure proper treatment and practice.

Acknowledgements

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Chapter 6

Understanding Practitioners' Responses to National Policy Guidelines

The Case of HIV Testing in Hospitals

Kabir Sheikh and John DH Porter

This chapter examines, in depth, the nature of urban medical practitioners'[1] responses to nationally promulgated policy guidelines for HIV testing, and in doing so, reflects on wider questions around practitioners' participation in public health processes and engagement with service ideals.

Medical practitioners are an important part of India's health workforce. According to the Central Bureau of Health Intelligence, there were 696,747 qualified allopathic doctors[2] registered with medical councils in India in 2007 (CBHI 2007). The majority of them work in cities and economically developed areas, and doctors are disproportionately under-represented in villages. It has been estimated that 75-80 per cent of allopathic doctors work in the private sector,[3] constituted of solo or small practices, nursing homes and larger hospitals, with the remaining 20-25 per cent manning government facilities (MOHFW 2005a; Peters et al. 2002).

The question of practitioners' response to globally and nationally recommended guidelines for diseases of public health significance is of central concern for public health programmes, and has been discussed widely in the literature. There are

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[1] The terms 'medical practitioner' and 'doctor' are used interchangeably in the text of the chapter.

[2] 'Allopathic' is a term used to define doctors who practice western biomedicine, as opposed to homeopathy or Indian systems of medicine which are also officially recognised by government.

[3] Including the private voluntary or not-for-profit sector which accounts for 1.3% of all healthcare establishments in India (MOHFW 2005b).

numerous reports that medical practitioners in both private and government sectors often do not comply with standard policies for the care of diseases and conditions of public health importance, such as HIV/AIDS, tuberculosis, malaria, sexually transmitted infections and diarrhoeal diseases (Singla et al. 1998; Uplekar et al. 1998; Mertens et al. 1998; Das & Hammer 2004; Kamat 2001; Chakraborty & Frick 2002; Sheikh et al. 2005a).

The existence of such divergent practices, or 'policy-practice gaps', are automatically assigned a strong negative value by policy experts and commentators. Compliance with guidelines by frontline providers is seen as a requisite for the success of public health programmes, and conversely, divergent practices on a large-scale imply programme or policy 'failure' (Mahapatra 2003; Peters 2003; Brugha 2003; Mills et al. 2002). Compliance with public health guidelines is widely used as an indicator to evaluate the quality of care provided (Das & Hammer 2004). In the Indian context, doctors' divergent behaviour has been interpreted variously, and often perceived to signify a disengagement of the medical community from ideals of public health and public interest (Das & Hammer 2004; Kamat 2001).

In this chapter, we attempt to examine the phenomenon of policy-practice gaps from a fresh lens — of the perspectives of the practitioners themselves. We focus our attention on a single area of importance in public health — HIV testing — to illustrate the relationship between national policy guidelines and the practices of frontline providers.

Methodology

The chapter is based on qualitative research, involving in-depth interviews with medical practitioners, and an interpretive approach of analysis. The interpretive approach seeks to understand the rationales within which actors think and act. Analysis is done by focusing on actors' expressions of real reasons, and motives for their actions, as opposed to those officially offered (Fischer 2003). In accessing these apperceptions and interpretations through in-depth qualitative methods, interpretive approaches account for the role of various factors, including beliefs, assessments of reality, values, self-interest

and power, in shaping actions and interactions; and also of actors' capabilities of change (Yanow 2000).

Face-to-face interviews (Grbich 1999) were conducted with 37 medical practitioners in five different Indian cities, between August 2005 and June 2006.[4] Principles of maximum variation selection (Silverman 2004) were applied to identify hospitals for the study, based on two criteria: type of hospital and geographical zone. Nine urban hospitals were selected, located in five cities, one each from the northern, western, southern, eastern and central zones of the country. These included four government hospitals, three private hospitals (including one large hospital and two private nursing homes), and two charitable hospitals.[5]

Individual study participants were identified from departments likely to be associated with HIV testing and

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[4] Only practitioners working in urban hospitals were selected in this study. Urban hospitals are important sites of HIV care, and health care in general. According to the report of the National Commission for Macroeconomics and Health, in the year 2000 there were 15,888 hospitals in India with a total of 719,861 beds. A majority of all hospitals (68%) are private; but 63% of all hospital beds are found in government hospitals (MOHFW 2005b). Government hospitals in cities cater to large numbers of people from all sections of society, but particularly the poor, including populations from urban slums, neighbouring villages, and even from distant states. Private for-profit hospitals can be found in a wider variety of organisational arrangements, from establishments run by individuals or household businesses, to small nursing homes with 1-20 beds, to large multispecialty hospitals run by private trusts or corporate houses. Private non-profit (charitable or voluntary) health care institutions account for 1.3% of the total health care enterprises in India, and similarly vary in organisational structure, from small clinics to large hospitals (MOHFW 2005a). In Indian cities, by a number of accounts, linked HIV tests are frequently conducted in institutional (hospital or clinic) settings at the behest of medical practitioners (Shinde et al. 2007; Kurien et al. 2007; Solomon 2006). Testing facilities for laboratory diagnosis of HIV are widely available in private and government hospitals in Indian cities.

[5] For the purposes of this study, only recognised practitioners in the allopathic system ('western' bio-medicine) and hospitals which employ allopathic doctors have been considered. The doctors who staff hospitals which constitute the 'formal' allopathic medical sector hold at least the basic MBBS degree, and in some instances, diplomas or degrees of postgraduate specialisation. Their professional qualifications and right to practice medicine are conferred by the Medical Council of India (MCI).

distributed across these departmental specialisations, using the maximum variation principle (Silverman 2004). The final number of participants was determined by adequate representation from different specialities. Of the 37 participants, 11 were women and 26 were men. The least experienced of these were residents or postgraduate students, and the most senior were professors and heads of departments with as much as 40 years of experience.

Table 6.1 *Study participants by hospital type and speciality*

	Physicians	Surgeons	Venereo-logists	Gynaeco-logists/Obst-etricians	Microbio-logists	Total
Government hospitals (4)	8	3	4	4	2	21
Private hospitals (3)	5	3	1	–	1	10
Charitable hospitals (2)	3	1	1	1	–	6
Total	16	7	6	5	3	37

All interviews were conducted by the first author, using a topic guide focused on respondents' participation in the implementation of HIV testing policies. Respondents were encouraged to discuss the topics at length, and interviews were guided by probes (Britten 2000).

The focus of enquiry is on four areas of the national HIV testing policy, first promulgated in 2003, from which doctors' practices have widely been observed to diverge (Kurien et al. 2007; Mahendra et al. 2006; MAAS-CHRD 2006; Sheikh et al. 2005b; Grover et al. 2003).

• The requirement of *specificity* in selecting patients for HIV testing
• Prohibition of *mandatory HIV testing* prior to surgery
• The requirement of specific written *informed consent* for a HIV test
• The requirement of strict *confidentiality* of patients' HIV test results

All practitioners interviewed were aware of the existence and the content of these guidelines, and in some instances, the hospitals which were part of the study selection had their own HIV testing policies, largely corresponding with the national guidelines.

Practitioners' accounts of their actions in the context of implementing HIV testing policies are first elaborated. The varying explanations and contexts for their actions which emerged from practitioners' narratives are thematically organised and elaborated. Frameworks explaining individual action in policy suggested by policy theorists Vickers (1965)[6] and Hjern and Porter (1981)[7] proved useful in categorising these themes. The thematic framework for organising and presenting the study data is presented in Table 6.2, based on Ritchie and Spencer's model (1993) of a combined deductive and inductive approach of analysis.[8]

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[6] Vickers (1965) proposed a simple model to explain the individual experience of making decisions in a policy context. According to him, policy actors make an appreciation of a given problem, by balancing their judgements around the 'facts of the problem' (reality judgements) with value judgements answering the question 'what ought to be?', in order to arrive at action judgements (what to do, and how to do it?).

[7] Hjern and Porter (1981) made the salient observation that organisations participate in several programmes, and the requirements of different programmes and of the respective organisation are not necessarily well-coordinated or mutually commensurate. Implementers, hence, often face a dilemma between serving the goals and objectives of a particular programme—the 'programme rationale', or of the organisation they work in — the 'organisational rationale'.

[8] The 'framework' approach of qualitative data analysis for applied policy research was developed by Ritchie and Spencer (1994) for the UK's National Centre for Social Research. 'Framework' combines a deductive and inductive approach, and involves the following steps:
  • Familiarisation with raw data
  • Identifying a thematic framework, based on pre-determined objectives, and field-level issues
  • Indexing, by applying the thematic framework systematically to the data
  • Charting, rearranging the data into distilled summaries of views and experiences
  • Mapping and interpretation, using the charts to locate concepts phenomena, typologies, and associations between themes

Table 6.2 *Thematic framework of analysis*

A priori themes	Experience of implementing each aspect of HIV testing policy — Specificity in selecting patients for HIV testing — Prohibition of mandatory HIV testing prior to surgery — Specific written informed consent for a HIV test — Confidentiality of the patients' HIV test result
Emergent theme categories	Account of actions in implementing policies (or not) Explanations for actions Related opinions and feelings
Analytical theme categories	Role perceptions and rationales Judgements of reality (what is) Value orientations (what ought) Action judgements (what to do, how to do it)

The Spectrum of Practitioners' Actions

It was apparent that medical practitioners' actions in the context of implementing HIV testing policies spanned the full range of possible responses to recommended national policy guidelines — compliance, partial divergence or total contravention. The range of practitioners' actions in implementing the policies, and their internal processes in taking decisions around action are described.

In many instances, medical practitioners did **comply with national testing policies**. Some practitioners indicated that they broadly shared the values of the HIV/AIDS programme, and hence were led to follow the policies. The practitioners who emphasised shared values with the HIV/AIDS programme were typically individuals who had had exposure to training on HIV/AIDS or otherwise regarded themselves as HIV specialists. Belief in certain values such as non-coercion, general informed consent and patient confidentiality, part of a larger medical professional ethic, were cited widely by these doctors. Working in government hospitals led medical practitioners to follow government procedures, and obedience to this organisational rationale was often put forward as an explanation of compliance. In many instances, compliance happened by default, since informed consent procedures were institutionalised in most of the larger hospitals.

In several instances, however, doctors complied with policies in spite of their explicitly stated disagreements with, or non-comprehension of, the rationales or values on which HIV testing policies were founded. Typically, this was a response to pressures from the hospital authorities to comply with policy recommendations. In these cases, the aim was usually to assure necessary paperwork, without an integral engagement with the principles of the procedure.

> *We have always taken informed consent. How much information the clients have understood is a separate issue. How do we validate or verify that? Humne to bata diya [We did what was required]. Now how much they have ingested, understood, we can't say that, we can't guarantee that.*
>
> — Senior microbiologist, government hospital (16)

This theme was particularly evident around the practice of specific written informed consent for a HIV test. Written informed consent for a HIV test was often seen as an inadequate signifier of the quality of the interaction. Respondents felt patients could easily be coerced or pressured into signing consent, which made the process liable for misuse by providers to safeguard their own position. Doctors were widely unconvinced or unclear about the rationale of the process, yet often adhered to the formalities of the procedure.

Some doctors specifically cited the utility of taking written informed consent as a legal safeguard. As a HIV specialist said, 'There have been suicides after HIV diagnosis, and without specific informed consent, the onus is yours. So why do that?'[9] Hence, doctors may have chosen to take informed consent on the basis of protecting their own interests.

In most instances, medical practitioners' actions actually approximated a point **between total compliance and total contravention of policies**. In the context of the likelihood of patient's dropping out, physicians reported that they tested some of their patients without undertaking a formal consent

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[9] Respondent 08: Physician and HIV specialist, eight years experience, government hospital

procedure: 'If a patient is too anxious, we can maybe just do an HIV (test) and see what happens.'[10] A subjective assessment of the patient guided these decisions, and the respondent stressed the importance of discretion in this regard. Numerous respondents indicated the importance of provider *discretion*, given that different patients had vastly differing needs and expectations. Judgements around involving patients' families and spouses in caring for them were felt to be particularly important. Discretion also determined doctors' interpretations of which health care staff were adequately closely involved in patient care to be allowed to access their HIV test results.

Frequently, policy violations were not the result of active decisions taken by doctors. Other patients in the consulting room often listened in on consultations, ascribed to culture as much as to overcrowding. Patients' relatives were often closely involved in care, and no steps were taken to prevent their knowledge of patients' HIV status. Health workers' 'grapevines' allowed them to have prior information about HIV status of patients when reports were released. A venereologist reported instances of breaches of confidentiality by nursing staff. Some efforts were made to redress these problems, but at the same time, concessions or adjustments were made to the situation, in the interests of *harmony*, productivity and the continuation of the core activities of the organisation. When faced with conflict, practitioners adjusted their behaviour by reorienting their positions vis-à-vis various involved actors, including administrators, co-workers and patients. These pragmatic adjustments were usually immediate and reflexive responses to specific situations, and seldom the result of a deliberative process.

Varying considerations of patients, co-workers and authorities, and situational constraints of time and resources represented the reality environment for doctors. In this context, strict adherence was not always possible to policies nor to personally held values, and *adaptability* was often regarded as a necessity, even a virtue. For a large part, these actions corresponded with Michael Lipsky's construction of the

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[10] Respondent 15: Venereologist, 10 years experience, government hospital

street-level bureaucrat, well-meaning and seeking to reconcile service ideals[11] with circumstantial constraints (Lipsky 1980). The practitioners sought to extract some value from the interaction, even if they were not able to comply entirely with policies. Circumstances may also have influenced practitioners' perceptions of the significance or the meaning of policies. Said a government hospital gynaecologist, 'Because we know that we are not able to maintain confidentiality, so we take it loosely...'[12] Particularly in government hospitals, following confidentiality policies was seen as an ideal, not necessarily a regular practice. 'These are ideals which have to be striven for, not necessarily to be achieved,' said one government microbiologist.[13]

Policies for informed consent and confidentiality were also violated outright in some instances. However, pre-surgical HIV testing was the most common example of **outright contravention of policies** by doctors. The perception of risk around acquiring HIV infection from surgical patients was the core consideration which led doctors to consciously contravene national, and, in the case of government hospitals, their respective institutional policies.

In the context of pressure from hospital authorities to officially comply with policies prohibiting pre-surgical screening, government surgeons could not use the formal hospital channels to conduct mandatory tests,[14] and instead resorted to subversive means such as sending their patients to nearby private laboratories to be tested, or by conspiring with hospital microbiologists to perform the tests unofficially. Hence, there was an 'underground' aura around pre-surgical testing in

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[11] However it is to be noted that medical practitioners' own service ideals, predicated more on the lines of an 'organisational rationale', did not always correspond with 'programme rationales' on which the policies were founded.

[12] Respondent 13: Senior gynaecologist and head of department, government hospital

[13] Respondent 16: Senior microbiologist, government hospital

[14] The 'appreciative' mix involved in conducting mandatory tests included reality judgements around the inadequacy of protective equipment, demands of co-workers, and the compliant nature of patients; combined with values around co-workers' rights and the economy of the testing procedure compared to purchasing expensive protective equipment. In some instances, it was linked to a rationale of scientific thoroughness and professionalism.

government hospitals. The general secrecy around pre-surgical testing did not favour good follow-up and care if a patient was found to be HIV positive.

In the following sections emerging reasons and contexts for practitioners' divergent actions are elaborated thematically as 1) conflicting perceptions of their roles or rationales of practice, 2) their divergent values and beliefs, and 3) their judgements of situational 'realities' and constraints.

Role Conflicts

Ambivalence in perceptions of roles and in rationales for action emerged as a common context for providers' divergent actions. Primarily, most doctors perceived themselves in the role of providers of clinical services. In many instances, their conceptualisation of the *healers' roles* was focused on the goal of the patient leaving the hospital in a well and not on ramifications and repercussions around the spread of the disease, or of psycho-social considerations of a stigmatised disease such as HIV. Consent procedures were often regarded as a hindrance in the fulfilment of this primary role. In the case of surgeons, their role perceptions were even more narrowly focused on the specific task of completing the surgical act successfully, and hence they tended to override the ban on pre-surgical HIV screening. The clinician's role was linked closely to workplace expectations and cultures, in turn oriented towards an understanding of care provision restricted to hospital boundaries. Hence, doctors' identities were shaped by their organisational roles as much as by membership of the medical profession.

In government hospitals, doctors more specifically linked their status of employment as *government servants* to their performance of roles. A perception of a public health rationale was also projected by some practitioners, with some doctors repeatedly emphasising the importance of detecting as many cases as possible. Government hospitals' traditional roles as surveillance centres may have influenced doctors to order HIV tests indiscriminately, even though the policies required greater specificity on their part in selecting patients for testing.

The clinical instinct to diagnose patients, especially those belonging to a scientifically 'interesting' category such as HIV/AIDS, may also have led to a greater propensity for advising HIV tests. Hence, doctors' role *identities as scientists* also influenced their behaviour in implementing testing policies. A few doctors among the selection regarded themselves as HIV *specialists*. They perceived that they were more emancipated than other doctors, especially around their recognition of PLHA's non-clinical needs, and ethical requirements such as consent and confidentiality. This segment of doctors avowedly subscribed to the human rights rationales and principles that corresponded with national HIV testing policies. Others militated against the exceptional treatment of HIV. One doctor from a government hospital remarked, '(In the hospital) HIV does not have more importance than others (diseases)...only as a part of the government programme.'[15]

The most apparent dilemma for doctors in implementing HIV testing policies was in reconciling the *organisational rationale*,[16] and the HIV/AIDS *programme rationale* (Hjern and Porter 1981). The hospitals' role as an organisation in its broader environment was to ensure the provision of care, strongly determined by concerns such as efficiency in ensuring patient wellness and turnover of patients, whereas the HIV/AIDS programme mainly required doctors to be cognizant of human rights principles through the enactment of specific procedures. As translated into guidance for action on the ground, these two rationales variously converged or conflicted.

Conflicting Value Orientations

Practitioners' values, beliefs and goal orientations often differed from the principles underlying the recommended policies, and led them to divergent courses of action.

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[15] Respondent 23: Senior surgeon, government hospital

[16] The organisational rationale, according to Hjern and Porter (1981), is a synthesis of the values and goals of its constituent programmes (of which the HIV programme would be one) and the niche of the organisation in its environment.

Doctors' emphasis on clinical outcomes and cure represented the value placed on expediting clinical tasks with *efficiency* and, in government hospitals, *economy*. The first of these tasks was diagnosis, and in this context, procedures such as consent for a HIV test were sometimes seen as unwelcome obstacles. The impulse to diagnose a patient was also indicative of the high valuation of the *scientific challenge* of the clinical procedure. Doctors fresh from training in HIV/AIDS care appeared to particularly cherish this aspect of their learning experiences. Different diagnostic tests were ordered to maximise knowledge about a patients' condition, to create a mental picture of the patient's condition ('knowing where we stand') in order to be able to 'take all the measures' for further management.[17,18] In some instances, the inclination to investigate may have overridden the requirements of the national guidelines such as specificity in testing, and attention to the autonomy of the patient in choosing to be tested.

In some cases, pre-surgical testing was regarded as an essential part of a thorough clinical work-up for patients. It was advocated in private hospitals as part of a package of infection control interventions, and was seen as a signifier of quality in the workplace, and linked to *professional values* around hygiene and safety.

In managing patients in hospitals, doctors appeared to follow unwritten rules of *equitable allocation of time and resources* among patients. Prioritisation was done on the basis of the seriousness of patients' condition, and the capabilities of the doctors and the resources to remedy it. One gynaecologist described the struggle to ensure good care for a large number of patients as 'the permanent dilemma between quantity and quality'.[19] In general hospitals, with patients with a wide range of serious illnesses, the needs of patients with HIV/AIDS were often not the most imminent, and non-clinical arguments in favour of HIV 'exceptionalism' (specific consent, counselling etc.)

[17] Respondent 26: Senior surgeon, private hospital
[18] Respondent 31: Microbiologist, 13 years experience, Private hospital
[19] Respondent 13: Senior gynaecologist and head of department, government hospital

did not have significant evocation for medical practitioners[20, 21] and many would have preferred to 'treat it like any other disease'.

Doctors generally approached problems from the position of belief in the innate *beneficence of medical interventions*, including diagnostic interventions. As one venereologist remarked, 'the smallest possible effort in India can help a person.'[22] The notion of informed consent for a HIV test, which is based around the possibility of a maleficent act (discrimination or stigmatisation) on the part of the doctors, challenged this core belief, and many doctors had problems in comprehending this rationale. Asking for consent from a patient for an essentially good service provided to them presented a contradiction. Doctors saw *diagnosis as a duty* toward patients, and part of their embedded functions within healing institutions. In government hospitals, this was further underscored by the awareness of the difficulties that poor patients underwent in accessing the free care that was available, and conceptions of the duty to ensure good clinical outcomes.

Relationships between patients and medical practitioners were often fundamentally asymmetric, and patients frequently asked doctors to make their decisions for them. While this may have been contrary to the reciprocal logic of informed consent procedures, which required patients and doctors to both be autonomous and mutually aware of their rights, it was seen by a number of doctors as a sign of *essential trust*, and valued greatly. Typifying the views of many respondents, one surgeon from a private hospital remarked, 'I think you have to be paternal in your attitude to patients...'[23] It is debatable whether the value ascribed by doctors to paternalism is a reality judgement (appreciation of social inequities, patients' rejection of autonomy), or a value judgement (valuing role of specialised knowledge, valuing dominance). Plausibly, it was a manifestation of doctors' recognition of the positive social role

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[20] Respondent 16: Senior microbiologist, government hospital
[21] Respondent 21: Senior surgeon, government hospital
[22] Respondent 07: Venereologist and HIV specialist, 7 years experience, government hospital
[23] Respondent 17: Senior surgeon, private hospital

of specialised knowledge ('he has come to you for help'[24]) in a society with strong asymmetries of knowledge ('many a time the patient's general intellect is not enough'[25]).[26] A number of respondents remarked on the personal validation perceived from being responsible for clients' well-being.

> *They all say, well doctor if it is your child what will you do? Whatever you would do for your child do the same we leave it to you. So there is a different relationship (from that in Western countries). That's one of the great things of working here (in India).*
>
> — Senior surgeon, private hospital (17)

In the words of one physician from a government hospital, 'Tomorrow my client and his well-being depend on me and it is a great feeling'.[27] He expressed regret that many doctors utilised this privileged position for self-aggrandisement. Beyond the egoistic gratification gained from the dominance of the paternalist position, there appeared to be a more complex value orientation. Patients' attitudes allowed doctors to serve unilaterally, to effect cure and relief to the suffering without contestation of the essential benevolence of their actions, and unadulterated by the doubt and confusions that underlie a reciprocal relationship. It was this privileged and possibly illusory position of unconditional giving that was highly prized by them.

Lastly, a key value consideration upheld by doctors was that of teamwork and *solidarity between co-workers*. The rights of all health workers to optimal protection from infection were invoked in defence of practices of mandatory testing. Fairness in allowing all health workers access to patients' HIV status was a consideration which contradicted existing policies around the confidentiality of HIV test results.

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[24] Respondent 25: Senior physician, government hospital
[25] Respondent 22: Senior physician, government hospital
[26] This is an example of overlaps between reality and value judgements that were often apparent.
[27] Respondent 08: Physician and HIV specialist, eight years experience, government hospital

'Reality' Constraints

Practitioners' assessments of situational factors and constraints, or 'reality judgements' (Vickers 1965), including shortages of time and resources, and relationships with different workplace actors, emerged as important contexts of divergent practices.

An important 'reality' for doctors was the *risk of infection* by a HIV positive person through the medium of needle stick injuries or in the course of surgical procedures. Although the likelihood of their being infected in scientific terms was very low, the fear of infection was considerable among most doctors, and particularly surgeons, and motivated indiscriminate HIV testing by doctors, especially pre-operatively by surgeons. The perception that routine protective equipment available to prevent cross-infection was inadequate also led surgeons to pre-emptively test their patients for HIV. In some hospitals, there were actual *shortages of gloves and protective equipment*. However, in other instances, administrators claimed that protective facilities were adequate, and that surgeons were widely misguided in assuming that advanced protective equipment was required to protect themselves, whereas in actuality simple practical measures could be taken to prevent infection. They (administrators) described this as a symptom of a sense of deprivation that prevailed among doctors, comparing their conditions with an imagined ideal of standards of facilities in the West.

Apart from a shortage of resources, doctors described their constraints in terms of *lack of time and* and *excess of patients*. For instance, the idea of strict confidentiality in a crowded consulting room with large volumes of patients and limited hours was described as 'completely impractical' by one gynaecologist in a government hospital.[28] In other instances, shortages of counselling staff were reported to limit the number of patients who could be offered tests.[29] Given a low staff to patient ratio, relatives of patients were usually co-opted to perform various basic tasks of care provision, in the context of

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[28] Respondent 13: Senior gynaecologist and head of department, government hospital
[29] Respondent 12: Junior gynaecologist, government hospital

which, confidentiality of patients' HIV status was highly improbable. In this environment of constraints and contingencies, a gynaecologist underlined the vulnerability of doctors to appraisal against unreachable standards, 'First these unrealistic polices are made, then you will criticise the doctors that they are not measuring up to the standards they are supposed to be following,' she said.[30]

Patients' actions and attitudes were key reality considerations for doctors. The attitudes of patients in government and private hospitals were widely reported to be inconsistent with autonomous decision-making. There were reports of patients not appreciating the consent procedure, and deep-rooted problems of comprehension of the information imparted around HIV testing, particularly in the case of poor, illiterate patients attending government hospitals. Reportedly, patients often approached the clinical encounter trusting the doctor to make the best decisions for them, and hence asking for written consent represented a rejection of sorts, of that expectation.

Further, patients' expectations were said to be usually oriented around receiving care for their complaints. In this context, formal procedures for consent and counselling were seen as time consuming diversions, especially when they required going to a separate room or department. In government hospitals, there were fears that patients would abscond when asked to consent and be counselled prior to a HIV test. In the private sector, often, introducing procedures such as specific consent and counselling around the HIV test was seen to be potentially offensive to patients, and hence antithetical to the aim of retaining patient custom. Retaining patients' custom was clearly a key consideration of doctors in both private and public sectors.

In some instances, staff who worked in operation theatres with surgeons clearly expressed their objections to participating in surgery on HIV positive patients. *Support staff are vital in the successful undertaking of surgical procedures*, and their perspectives were given considerable importance by surgeons. Concerns around the risk of HIV infection through

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[30] Respondent 13: Senior gynaecologist and head of department, government hospital

needle-stick injuries for nurses, paramedical staff and hygiene workers were voiced by doctors in all sectors of hospitals. Health workers widely felt that they needed to know which patient was HIV positive, and they resorted to the informal 'grapevine' and devices such as labelling of case files or beds to make identification easier. Such practices were widely tolerated by doctors.

The 'Appreciative' Mix

The findings of the study reveal the complex and nuanced nature of practitioners' response to public health guidelines. Significantly, divergent practices did not necessarily denote a rejection of service ideals, and nor did outward compliance always imply engagement with the underlying principles of the guidelines. Typically, policy guidelines were taken 'loosely' or flexibly by doctors, who followed logics of discretion, maintenance of harmony and adaptation to the needs of situations and of other stakeholders, addressing value considerations where possible. Outright contravention was seen, in some instances, particularly in the context of pre-surgical HIV screening, marked by a sense of secrecy. In a number of instances, doctors did comply with policies, motivated by shared values with the HIV/AIDS programme, or by a sense of obedience to institutional or governmental norms.

Compliance with existing policy guidelines was but one of multiple considerations in practitioners' minds, in making decisions around how to act (Lewis and Flynn 1979). A mix of conflicting role perceptions, value orientations and pragmatic 'reality' considerations underlay practitioners' actions. Value based and practical explanations were not always distinct, but sometimes overlapped dialectically in respondents' narratives — perceptions of realities often determined what actors ascribed greater value to, and conversely values shaped their perceptions of reality.[31] Hence the rationalisations or explanations for

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[31] For instance, cognizance of deep asymmetries of knowledge was linked to the value that practitioners ascribed to paternalism; knowledge that patients often 'drop out' when faced with lengthy consent and counselling procedures may have led doctors to value patient retention over the importance of taking consent.

actions that were cited are best described as an 'appreciation', an amalgam of philosophical and pragmatic considerations (Vickers 1965).

Figure 6.1 summarises the varying explanations of practitioners' divergent actions that emerged from their narratives. The value orientations which variously influenced doctors' actions included clinical efficiency, scientific challenge, professionalism, equity, sense of duty to treat, and paternalism. Practical considerations or 'reality judgements' included the nature of relationships with co-workers and patients, and cognizance of problems of resources, time and space, large patient loads and systemic unresponsiveness. Themes around conflicting reality judgements and value orientations often resonated similarly among public, charitable and private sector doctors.

Role / rationale ambivalences	Conflict between roles: – Clinical service provider – Scientist – Government servant (G) – Public health worker Conflict between organisational rationale and programme rationale	
Reality judgements conflicting with compliance to policy ('What is')	Risk of infection Context of lack and deprivation (G, C) Patient actions and attitudes Co-worker needs	**Action judgements** ('What to do and how to do it')
Value orientations conflicting with compliance to policy ('What ought')	Clinical efficiency Economy (G, C) Scientific challenge of diagnosis Equitable treatment of patients in the hospital (G, C) Professional thoroughness (pre-surgical screening) (P) Essential beneficence of medical encounter Duty to diagnose (G, C) Trust and paternalism Rights of medical providers	Flexibility / discretion Contravention Superficial compliance

Figure 6.1 *The appreciative mix: explanations of practitioners' divergent actions*[32]

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[32](G) refers to government hospital practitioners, (C) to charitable hospital practitioners and (P) to private hospital practitioners

Conclusion

In this chapter, we have elaborated the complex of meanings which doctors referred to in making decisions around action. In the Indian and other developing country contexts, medical practitioners and other health systems actors have largely been viewed in terms of their instrumental roles in the implementation of public health policies, and there are very few examples of studies which explore their perspectives, particularly their ideational capabilities and purposive natures. Miljeteig and Norheim (2006) have addressed similar themes in their study of neonatal care in an Indian government hospital, reporting that the doctors referred to ethical frames in making decisions, which differed from accepted Western bio-medical ethical norms. Apart from this, there are no known instances in the literature of explorations of Indian doctors' systems of values and meanings from an 'emic' perspective.

Of particular relevance are the observations around doctors' sense of purpose in their work, shaped as they were by a composite of interests in the performance of healing functions, in the science of medicine, and in the fulfilment of organisational and social roles.[33] As noted before, doctors tended to focus more on performance of core tasks — mainly clinical tasks such as ordering investigations as part of clinical management, and performing surgery — than on conformance with policies (Barrett and Fudge 1981).

Practitioners from government and charitable hospitals cited a range of motivations for performance, identifying with roles as healers and as scientists, and also by a strong recognition of their respective hospitals' roles as sources of good quality, affordable health care in a society with high levels of poverty. Doctors in private hospitals were somewhat more narrowly focused on addressing their individual healing functions, and to some extent in the scientific aspect of HIV care, and unlike charitable and government hospital practitioners, did not cite broader social roles

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[33] Additionally, issues involving overt self interests and the protection of self interests were usually discussed by doctors in terms of invocation of their rights — the rights to safety, and to financial and job security.

and developmental concerns as being addressed through their work.[34]

Overall, the sense of purpose exhibited in the accounts of most of the doctors (private and public) contradicts the hypotheses of some authors, of a widespread moral and ethical disengagement with their work on the part of Indian doctors, typically ascribed to overriding commercial interests (in the private sector) or indifference (in case of government practitioners) (Das & Hammer 2004; Kamat 2001; Jesani 1997). It was heartening that practitioners in both the government and private sectors revealed a desire for, and pursuit of, meaning in their work, even if these pursuits often took them in directions which differed from expected norms in the context of policy implementation.

From an interpretive perspective, policy-practice gaps may hence be seen to result from an essential difference in perspectives — the 'systems of meaning' (Yanow 2000) that doctors inhabit are often at odds with the more widely recognised and acknowledged logics of public health systems and programmes — and leads to divergent courses of action (Rein and Schön 1993). We argue that medical practitioners' divergence from guidelines does not necessarily equate with disengagement from service ideals, and should not necessarily be seen to amount to policy failure. Divergences are underpinned by alternative ways of seeing and acting, and contain the potential for learning and innovation (Healey 1993).

As street-level implementers, medical practitioners are a key link that systems and programmes have with the recipients of services, and it is particularly important not to allow their perspectives to be neglected (Lipsky 1980). Even as strategic approaches in health policy are largely directed towards modifying the behaviour of practitioners to conform to the intentions of policymakers, there are also significant

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[34] Among private practitioners, the phenomenon of lesser identification with socio-developmental roles may be understood in the context of their relative isolation, an explanation which was also advanced by Jeffery (1988) and Madan (1972, 1980). Many private practitioners, removed from meaningful exchanges with peers, with public health systems, and from most substantive interactions except with patients, tended to perceive themselves in the narrow role of care providers, and less as contributors to wider social goals (or as 'modernisers', a term used by Madan (1980)).

opportunities for policy to be informed by the perceptions, values and experiences of frontline practitioners. Understanding these (sometimes divergent) perspectives, and acknowledging their possible legitimacy, is a step towards achieving mutual understanding between public health systems and medical practitioners, and towards a better realisation of doctors' potential roles in public health and society.

Acknowledgements

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Chapter 7

The Dynamics of Medicos'
Anti-Reservation Protests of 2006

A Lens on Their Political Actions

V Venkatesan

T his chapter looks at the character of the anti-reservation
agitation in elite medical educational institutions in 2006.
This particular mobilisation of medicos took place in the context
of the amendment of the Constitution of India, in which a new
clause (5) was added to Article 15 to facilitate reservations for
socially and educationally backward classes (SEBCs) in
educational institutions, and the unanimous enactment in
Parliament of the Central Educational Institutions
(Reservations in Admissions) Bill, 2006. The agitation was
conducted in defiance of the authority of elected legislators, and
marked by underlying caste biases. The medicos involved in
the movement claimed to be distinguished by anti-political
sentiments and found support in sections of the elite in civil
society, and even the judiciary.

As the author of this chapter, my own familiarity with anti-
reservation agitations can be traced to the day when my
journalistic career began. It coincided with the announcement
by the then Prime Minister V P Singh, in August 1990, of 27
per cent reservation for the Other Backward Classes (OBCs) in
Central services.[1] I draw much of the substance about the anti-

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[1] The origin of the use of the word 'Other' before 'Backward Classes' is a mystery,
while the term OBC itself is a misnomer. It is generally understood to refer
to classes other than Scheduled Castes and Scheduled Tribes. While the
Constitution, at some places, includes SCs and STs under the broad category
of backward class of citizens, the backward classes is generally the preferred
term to describe the socially and educationally backward classes, who are not
SCs and STs. This article will, where it is not contextually necessary, avoid
the use of the word 'Other' to refer to the backward classes, to ensure clarity.

reservation agitation in the 1990s from the compilation of my own writings in the Times of India, where I worked at that time. A website run by the agitators against the reservations, and their petitions in the Supreme Court offered information about their position and grievances.

The 2006 agitation is too recent for an observer to keep a safe distance from the emotional, moral and legal underpinnings of the controversy. Moreover, recent agitations around the implementation of the ruling demonstrate its yet unresolved tensions for all those concerned (*The Hindu*, 25 April 2008). My close personal involvement in the processes of covering these events cannot be divorced from this commentary. My experiences led to realisations of the fundamentally perilous nature of aspects of the debate for the polity, and to critical questions of how elites contest democracy, equality and the rule of law — themes which I seek to illustrate in the pages to follow.

Ever since independence, reservation for backward classes has been a contested issue, and the past two decades have witnessed their fair share of protests. The years 1990 and 2006 are key landmarks in the history of these protests, coinciding with the implementation of different sets of government policies. Over time, it is medical students and doctors in particular, who are taking a prominent role in leading the agitations against reservation. This chapter revisits the anti-reservation agitations of the 1990s to provide a background to the events that unfolded in 2006. Analysis of the nature of the 2006 agitations reveals that medicos as an elite group mobilise against the rule of law, oppose Parliamentary processes, and express caste prejudice; yet, unlike other anti-state movements, they still attract strong favour from sections of civil society and the judiciary.

Reservation Policies: A Contested History

Galanter (1984) uses the expression 'compensatory discrimination' to describe India's system of preferential treatment for historically disadvantaged sections of the population. This system led to an array of programmes that reflected an awareness of the entrenched and cumulative nature of group inequalities. Provisions for mandating reservations for Scheduled Castes and Tribes (SCs, STs) in elected legislative

bodies, and provisions enabling reservations in public employment and education for these groups were inserted in the Constitution in 1950 at the time of its adopting, and in 1951, through the First Amendment, respectively. Galanter, who studied the practice of compensatory discrimination for the first 30 years, believed that it was pursued with remarkable persistence and generosity, even if not always with vigour and effectiveness.

Despite Galanter's favourable assessment, India's positive discrimination policy has experienced active contestation in terms of achieving its avowed objective of emancipating backward groups. To understand the most recent contestation in 2006, one must recollect the character of a similar agitation launched by the students in 1990. That agitation was almost spontaneous, following the notification of the Office Memorandum, fixing the quota of 27 per cent for OBCs by the then government led by Prime Minister V P Singh, on 13 August 1990. The 1990 Office Memorandum was based on the Mandal Commission Report on Backward Classes, submitted in 1980.

The deprivation of an opportunity to join the public services was something the youth belonging to the upper castes felt aggrieved about, and took to the streets to register their protests. The role of anti-social elements and hoodlums in the 1990 stir was widely reported in the print media. Violent demonstrations were the order of the day, and a youth, Rajiv Goswami, attempted self-immolation.[2] In all, there were nearly 200 suicide attempts, of which 62 were successful. Police fired against the agitators in eight states, claiming 58 lives.[3] The agitators had also procured support from political actors and parties that had individual grievances with the policies.[4]

The official who drafted the notification, P S Krishnan, later an advisor to Arjun Singh when he was the Union Human

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[2] He survived this event, but died several years later on 24 February 2004.

[3] Christophe Jaffrelot's book, 'India's Silent Revolution: the Rise of the Low Castes in North Indian Politic', includes a table on cases of self-immolation, suicides and casualties of police firing during the anti-Mandal agitation, sourced from National Mail, 12 January 1991.

[4] Among these was Mahendra Singh Tikait, whose grievance was that a particular caste was excluded from benefiting from the policies put forward by the Mandal Commission.

Resources Development Minister in the 2004-09 United Progressive Alliance (UPA) government, told this writer in an interview that the government then was inclined to extend the reservations policy to admissions in educational institutions,[5] but refrained from doing so because of the violent agitation that greeted the introduction of OBC quota in public services. The violence would have become unmanageable had the OBC quota been extended to educational institutions, he said.[6]

The agitation then subsided after the Supreme Court heard a challenge brought by an advocate, Indra Sawhney, against the notification of 13 August 1990 (Chandra et al. 2000).[7] Three years later, another signpost in the maturing of Indian democracy passed with little disturbance, showed society being more accepting of the same reservation policy it had so actively contested earlier. The notification of the OBC quota by the Central Government in 1993, after the Supreme Court's verdict in 1992 on the Indra Sawhney case, was met with general indifference. The student violence sparked by the implementation of the notification ebbed away. It would seem that the upper castes ceased to resist this particular reservation order and resigned themselves to the rule of numbers.

Jaffrelot (2003 P:366-67) argues that the acceptance by upper castes of the 1992 Supreme Court decision and the 1993 notification was the result of changes in the economy which displaced the perceived negative value of reservation policies. He suggests that the economic liberalisation that was set in motion in 1991 provided the upper castes with a safety net. As a result, careers in the private sector had become more attractive and, therefore, upper castes felt there was no need to fight for

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[5] The Mandal Commission Report, apart from recommending 27 per cent reservation for OBCs in public services, had also recommended similar reservations for admissions in educational institutions.

[6] Interview with Mr. P.S.Krishnan in March 2007.

[7] The petitioner challenged it on three main grounds: one, the OBC quota violated the Constitutional guarantee of equality of opportunity; second, caste was not a reliable indicator of backwardness, and three, quota threatened efficiency of public services. The Supreme Court gave its order on 16 November 1992, upholding the validity of the OBC quota on the condition that the 'creamy layer' would be excluded from the beneficiaries of the quota. The government had then evolved reasonable criteria to exclude the creamy layer category from the OBCs.

their traditional positions in the bureaucracy. Alongside the expansion of private sector employment, thanks to India's tryst with economic reforms and globalisation, was a boom in higher education. These changes meant that OBCs began to understand their empowerment in terms of not only a share in the public services, but also in, and through, higher education, of a share in employment in the private sector. The Indian state's efforts in 2006 to introduce positive discrimination in higher education in favour of the OBCs in centrally-funded institutions across the country in admissions have to be viewed in this context.

2006 Medicos' Agitations: A Movement Apart

On 5 April 2006, the then Human Resource Development Minister Arjun Singh told mediapersons that the government proposed to introduce 27 per cent reservation for OBCs in central universities, the Indian Institutes of Technology (IITs), the Indian Institutes of Management (IIMs), central medical colleges, including the All India Institute of Medical Sciences (AIIMS), and a few other centrally-run elite institutions. In response, medical students and doctors were at the forefront of the protests against this reservation measure. On 26 April 2006, students of five leading medical colleges in New Delhi went on strike. Junior doctors in New Delhi joined the strike on 14 May 2006. Scores of junior doctors in Mumbai, and junior doctors and medical students in Bangalore also joined the protest. In this section, I detail how the nature of this elite agitation, while espousing democratic, apolitical and egalitarian ideals, was in fact a political mobilisation that distrusted and defied Parliament, espoused caste prejudice, and yet, unlike other anti-state movements, received conciliatory backing from the judiciary.

The origins of the uprising of medical students and doctors were described in the website *www.youth4equality.com* as follows: 'Some students in the University College of Medical Sciences (UCMS), New Delhi, met at the boys' hostel to ponder over the situation and decided to create the Youth for Equality (YFE). They met their friends in the four other medical colleges of Delhi, who expressed similar feelings of resentment towards

the reservation policy, thought they should do something about it, and had no hesitation about joining the YFE.'

'Driven by idealism, passion, and courage of youth, the YFE soon became almost a nationwide movement,' the website claimed.[8] Soon, there were students of IITs, IIMs, and colleges of science, art, law, and engineering joining the uprising.

The YFE's website said that Arjun Singh's announcement led to a combination of grief, distrust, anger and betrayal. Many young people, it said, were dismissive of the move, and thought it was only another gimmick aimed at attracting votes. The chief demand of the YFE was that the newly instituted policies granting 27 per cent reservation to OBCs in higher education institutions be withdrawn. In substance and in method, their demands contained considerable contradictions, some of which are illustrated in the box.

MEDICOS' KEY DEMANDS AND THEIR CONTRADICTIONS

YFE's Charter of Demands opposed reservation on the basis that it was a limited step to provide opportunities for the backward sections in education and employment. It is widely acknowledged that reservation is no more than a limited step to provide opportunities for backward sections. The YFE did not cite alternative measures for their uplift.

The website proposed that a non-political, non-Parliamentary commission with members from judicial, educational, scientific and social science backgrounds should be formed to devise a *fool-proof and time-bound strategy to uplift and empower backward sections without interfering with the nation's overall development and well-being*. There was, however, little indication on why the government's proposal was not considered to be 'foolproof', and no substantiation of the claim that it was unlikely to uplift backward sections or that it would affect the nation's development and well-being.

The charter demanded that an independent commission should propose a *time-bound strategy* to uplift

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[8] www.youth4equality.com. The website is now extinct.

the backward sections. This appeared to neglect the fact that the government was adhering to an advertised timeframe for implementing reservation for OBCs from the 2007 academic year.

The YFE demanded that *government positions* that were vacant because of the lack of eligible candidates from the SC/ST categories should be opened for other eligible candidates immediately. This was somewhat irrelevant to the current controversy, which was around reservation for OBCs, rather than for the Scheduled Castes and the Scheduled Tribes, and in educational institutions rather than government jobs.

From the tenor of their demands, it appeared that these young activists were driven less by an informed perspective and specific grievances caused by the reservation for OBCs, and more by emotions and a vague sense of resentment against the reservation policy in general.[9] The drawbacks and inconsistencies of the arguments notwithstanding, the YFE was aggressive in promoting their cause. As the backing from the corporate sector became obvious, the elitist, neoliberal, pro-globalisation character of the movement became pronounced. The website also claimed that parents, resident welfare associations and corporate bodies backed the agitation. The YFE proudly announced on its website the launching of its unit in the United States.

Distrust and defiance of parliament

The government, in response to the agitating students, promised no reduction in the total number of seats available in the medical institutions under the central government for non-reserved

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[9] One of the writ petitions filed in the Supreme Court by some of the organisations representing the agitators had challenged the validity of the 2006 Act reserving seats for SEBCs in these words: 'The statute has lost sight of the social catastrophe it is likely to unleash. The products (of the educational institutions, if the BCs had reservations) would be intellectual pigmies as compared to normal intellectual sound students presently passing out'. See Supreme Court's interim order in Ashoka Kumar Thakur Vs Union of India and Others, 12 March 2007. Ashoka Kumar Thakur, the main petitioner, is an advocate in the Supreme Court.

categories, and creation of the necessary infrastructure by June 2007, when the reservation in the central educational institutions would come into force. A 13-member Oversight Committee headed by the then Administrative Reforms Commission Chairman M Veerappa Moily was set up to monitor the implementation of reservation for OBCs in institutions of higher education. The Moily Committee, while preparing a blueprint for the creation of such infrastructure, did not examine the issue of exclusion of creamy layer from the beneficiaries of OBC reservations in admissions to higher educational institutions, leaving the question to be decided by the judiciary. In addition, the government set up three separate groups to draw up modalities for implementing the decision in engineering, management institutions and central universities, respectively, requiring them to submit their reports before 31 July.

These measures announced by the government, including the proposed increase in the number of seats and the exclusion of the creamy layer, appeared to be in consonance with the demands of the YFE.[10] Still, the YFE revealed a distrust of the government and Parliament and wanted a non-political commission to review the existing reservation policy. This commission, to be headed by a retired Chief Justice or a retired judge of the Supreme Court, would purportedly go into such basic questions as whether reservation on caste basis is in the interest of the country. The YFE also urged that the report of the proposed commission be tabled in Parliament, and that the MPs discuss it thoroughly within a reasonable time of the finalisation of the report. Although the YFE did not spell out whether Parliament could reject the report, it appeared that it would not support such an option. The YFE's demands and their defiance of Parliamentary authority was particularly remarkable, given the context that the reservation policy represented a rare occasion when Parliament had already unanimously approved the reservation policies as a legislative measure intended to uplift the backward classes.

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[10]The government appeared to have an open mind on the question of creamy layer, even though the Central Educational Institutions (Reservation in Admissions) Act, 2006 was silent on this, and this silence apparently created the misgivings among the agitators.

Judiciary conciliation

As medical students and junior doctors all over northern and western India struck work, health services were brought almost to a standstill in a large part of the country for over two weeks. In this context, a close look at the response of the judiciary to the suspension of essential services is in order. On 31 May 2006, resident doctors of all the five premier medical colleges in Delhi called off their 20-day anti-quota strike, averting a face-off with the Supreme Court, which ordered them to end their agitation. A Bench comprising Justices Arijit Pasayat and Lokeshwar Singh Panta held that the patients have a right to get treated under Article 21 of the Constitution of India.

Earlier on the same day, the Supreme Court, in a conciliatory gesture, directed that disciplinary proceedings, notices and departmental actions initiated against doctors should also be withdrawn within three days of their resuming work. Furthermore, the Bench also waived the rule of 'no work - no pay' in favour of the striking doctors. The Bench appeared to interpret the government's readiness to withdraw disciplinary proceedings, notices and departmental actions against the striking doctors, to include the payment of salaries, and threatened that refusal to pay would be construed as contempt of court. The government on its part made no effort to explain to the Bench that the suspension of disciplinary proceedings was distinct and separate from considerations of 'no work - no pay', The Bench's extraordinary intervention to help the striking doctors came in for criticism. The 'no work - no pay' rule enjoys legal sanction, and the compliance of the government and judiciary in abrogating this rule in this regard is remarkable. There is considerable scepticism whether the judiciary would have come to their rescue if the strikers were not medicos.

Further, one of the petitions challenging the validity of the OBC quota in educational institutions described the beneficiaries of the quota as 'intellectual pygmies'. Such an offensive description in any other matter would have resulted in the dismissal of the petition by the court at the preliminary stage, or at least a direction from the court to the petitioner to redraft the petition without offending anyone. But the Supreme Court admitted the petition, and included the objectionable phrases found in the petition in its Interim Order issued on

29 March 2007, granting a stay on the implementation of the reservation till the court decided the matter (*Frontline* 2007). This is but one reflection of prejudices and deep caste divisions within both the judiciary and the medical community.

Caste prejudice

The caste prejudices of the medicos who mobilised against the reservation policy also became apparent through their reaction against those who disagreed with them, and through study findings that revealed the practice of caste prejudice in medical institutions. Even as the junior doctors and students were agitating against the OBC quota, a section of doctors, albeit small in number, also registered their protest against the agitation and the discrimination against students belonging to SCs, STs and OBCs. In the wake of media reports and complaints to the government about the harassment and abuse of SC/ST students in AIIMS, the government constituted a committee headed by University Grants Commission Chairman Professor S K Thorat to enquire into allegations of differential treatment of students of these sections in AIIMS.

The committee in 2007 reported its findings about the anti-quota agitation thus: 'The anti-quota agitation was planned by a group of people who had strong views against the reservation bill to be passed soon in the Parliament. Various people have given evidence to support the view that the administration of AIIMS played a proactive role in the organisation of the agitation. AIIMS became the venue for this so-called national agitation because it could paralyse health care services to thousands, and thereby attract public attention. Paralysing of the health care services, including emergency services, would put pressure on the government. The administrative support, which was widely covered in the media, went to the extent of penalising and punishing several students and staff who did not support the agitation' (Thorat 2007). Chapter VI of the report contains the following narration: 'The discrimination of the SC/ST community in AIIMS, which was prevalent for several years at a lower intensity, became heightened and noticeable in the immediate post anti-quota agitation period. The polarisation

of the groups and the acrimony that the agitation developed among the various groups had its most deleterious effect on the students, who were the most vulnerable.'

The YFE organised a strike from 13 May 2006, and drew instant support from the AIIMS Students' Union, Resident Doctors' Association and from Faculty Association (FAIIMS). Some of the senior faculty, residents and students who met the committee, were opposed to the agitation and had appealed to the president of AIIMS (the then Union Health Minister, Anbumani Ramadoss), alleging direct involvement of the then AIIMS Director P. Venugopal and the administration in organising the agitation. Students of SC/ST group alleged that they wanted to attend classes but were ignored by the faculty.

The report recalls that the same AIIMS administration had strictly applied a court order banning agitations within 500 metres of the AIIMS on previous occasions when workers went on strike. But this time, the striking students and resident doctors had located themselves in the central lawns, oblivious of the court's ban. About 50 to 100 persons were on hunger strike at this venue. The erection of *shamiana*, provision of electricity for coolers, and other comforts such as mattresses and pillows, the committee learnt, would not have been possible without the support of the administration. In contrast, when the faculty, residents and students who were pro-reservation wanted to protest by organising a rally, the administration acted swiftly to put an end to the rally by seeking police help. The students, residents and faculty also complained to the president of AIIMS about the involvement of the Medical Superintendent in calling the faculty to report for hunger strike.

The pro-reservation students alleged that Director Dr. P Venugopal instigated and provided patronage to anti-reservation elements in the campus, which culminated in the strike and shutdown of the institute. The committee found that punitive action was taken against several of the residents who participated in the pro-reservation protest. The committee noted with dismay the harassment of Dr. Ramesh Deka, the then Dean of AIIMS, by the leaders of the anti-reservation agitation with the alleged backing of the AIIMS Director. Dr. Deka was one of those who did not cooperate with the agitators, and, therefore, had to face reprisals.

More disturbing though is the general climate of discrimination against the SC/ST students in AIIMS, as brought out in the report. AIIMS, according to the report, had not taken any initiative to arrange remedial coaching in English, basic courses or any other spheres for SC/ST students, as is required by educational institutions. About 84 per cent of the SC/ST students mentioned to the committee the need for remedial coaching in English and basic courses. The committee also found that the SC/ST students did not receive the kind of support that the other students received from their teachers. Given the dependence of students on teachers for learning and skill, the lack of adequate support to the SC/ST reflected in performance and psychological problems, the report lamented. The self-reported experiences of SC/ST students indicated to the committee that discrimination in AIIMS took the form of avoidance, contempt, non-cooperation from the faculty, and discouragement and differential treatment by teachers towards the students. The committee also found that the institution was guilty of practicing a serious form of social segregation in the wake of the agitation against OBC reservations. It noted with concern that several students belonging to the SC/ST categories had shifted to the two top floors of Hostels 4 and 5, leading to some sort of segregation on caste lines. The SC/ST students were forced to shift to these hostels by a sustained pressure in the form of humiliation, abuse and even violence by the higher caste students. About half of the respondent students indicated to the committee that caste harassment by higher caste students was the reason for shifting from other hostels to Hostels 4 and 5.

Conclusion

In contrast to the agitations of the 1990s, the 2006 agitation against the central government's announcement to reserve 27 per cent seats for OBCs in admissions to central higher educational institutions was not as ferocious. The sense of deprivation was first articulated by a section of the youth, especially medical students, and later by a few self-styled but influential leaders of civil society (but not including the political class), who persuaded other sections of the upper caste youth to support the agitation. Further, several of these influential

individuals,[11] who supported the agitation also filed petitions in the Supreme Court in their individual capacities, challenging the OBC quota in higher educational institutions. As the medico-led agitation of 2006 unfolded, it became evident that it had several characteristics that set it apart from other anti-state movements across the country.

'It is not only youth for equality; it is country for equality,' proclaimed a banner at a rally organised by the YFE at the Ramlila Grounds in New Delhi on 27 May 2006. On the face of it, none could object to the association of the youth with the country at large. However, one could hardly miss the distortion of value-neutral expressions such as youth, equality and country by the elite spearheading the agitation. The assumption of the right to speak by the agitators on behalf of the entire country in opposing a policy measure unanimously approved by Parliament, has disturbing implications for the polity.

The YFE's month-long stir smacked of contempt for Parliamentary democracy, and this is a frightening aspect, especially because it opposed a legislative measure backed by the collective will of Parliament, not just the majority of its members. This devaluation of Parliamentary democracy in the context of the growing space for neoliberal policies raises the question whether the attack on reservation actually stems from a mindset fundamentally opposed to the progress and inclusion of deprived sections. There is an implicit bias in the anti-reservation agitation against the inclusion of those hitherto excluded from the education process, and this bias gets its sustenance from the racial argument that the members of the excluded group do not possess the requisite intelligence or aptitude for higher studies.

Unlike the agitators against Mandal I (1990), the current agitators against Mandal II decision come from the middle classes, a part of the globalised elite. The support of the faculty of the elite institutions to the agitation shows that they value 'institutional merit' — understood in terms of their global standing — more than the merit of individual candidates, which

[11] P.V. Indiresan and Shiv Khera are some prominent individuals who had filed separate petitions in the Supreme Court challenging the OBC reservations.

may not be compromised at all by the quota for the OBCs. A reluctance to perceive 'institutional merit' in the sense of empathising with ordinary people characterises this blind opposition to OBC reservation.[12]

The report submitted to the government by Prof Thorat, Dr K M Shyamprasad and Dr R K Srivastava has very disturbing findings about the prevalent social climate in AIIMS towards weaker sections. Although the anti-OBC quota agitators point out that their opposition is only to the quota for OBCs, and that they do not question the constitutionally-mandated reservations for Scheduled Castes and Scheduled Tribes, the committee's findings point to serious lack of commitment among the students and faculty of AIIMS to SC/ST reservations as well.

The courts' role in conceding and conciliating with doctors reflects the subtle message that the doctors in society constitute a special elite group, and the ordinary rules of conduct, applicable to other sections of society, do not apply to them. If the doctors do end up on the wrong side of the law, the law should bend and reach out to them, to bring them back into the mainstream through reconciliation and props.

Ironically, it contradicted the doctors' own standpoint on the reservation issue. The doctors protested against the OBC quota because they claimed it militated against the principle of equality. On the contrary, they had no qualms in sacrificing the same principle when it came to the question of restoring their pay and privileges for the period when they went on an illegal strike. If the striking doctors had the courage of conviction, would they not have foregone their salaries for the strike period and faced disciplinary proceedings like any other section of the society would have had to under similar circumstances?

There are many troubling questions around the compromise of democratic principles, to which there were no answers either from the doctors, or from the judiciary. The students and junior doctors of AIIMS had temporarily given up the path of confrontation with the government on the quota issue, in order

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[12] Notes taken from an address by economist Prabhat Patnaik at a meeting, organised by the Jawaharlal Nehru University Students' Union on the anti-quota agitation in May 2006.

to await the outcome of their legal challenge to a statute unanimously passed by Parliament. Even as they preach equality in the social market place, if only they held a mirror in front of themselves, some of their own ugly manifestations of social and caste prejudices might have made them introspect about the hypocritical character of their agitation against the government's efforts to make higher education more inclusive than it has been so far.

Postscript

The judgement delivered by the Supreme Court's five-judge Constitution Bench on 10 April in the Ashoka Kumar Thakur case vacated the stay on the implementation of the reservations for the SEBCs in admissions to government educational institutions, but directed the government to exclude the 'creamy layer' from the Backward Classes before extending 27 per cent reservations to them. The Bench unanimously held that the quantum of 27 per cent reservations for BCs is not illegal, and that merely because time limit has not been prescribed for reservation, the Act providing for reservations cannot be set aside as unconstitutional. The Bench also called for a periodical review of the lists of SEBCs once in every five years (*Frontline* 2008).

But the four different judgements, (delivered by Chief Justice K G Balakrishnan and Justices Raveendran, Arijit Pasayat and Dalveer Bhandari) seeking to answer as many as 20 questions on the policy of reservations, were far from offering clarity on the issue, even while aiming at balancing the contending interests. The question which was of concern to the agitators was whether the majority judges of the Bench disapproved of reservations in higher educational institutions. That was because three of the five judges held that graduation should be the benchmark to determine whether a person has ceased to be socially and educationally backward, in order to avail the benefits of reservations. The government interpreted it to mean that if a substantial number of persons in a Backward Class are graduates (say, more than 50 per cent), then that class (here caste is construed as class for the purpose of identification) should be excluded from the list of SEBCs so determined by

the Government. This depends on whether the periodical review carried out by the government indeed reveals such cases among the castes which currently figure in the list of SEBCs.[13]

But the agitators (some of whom later approached the Supreme Court as petitioners in the Ashoka Kumar Thakur case) continued to insist that the majority judges in this case indeed held that individual graduates must be excluded, like creamy layer, from availing the benefits of reservations for backward classes. The issue is far from resolved and is likely to be the subject matter of a fresh legal battle in the Supreme Court. But the court's 10 April verdict clearly shows that some of the concerns of the agitators who disrupted normal life across the country during mid-2006 were clearly misplaced, and that Parliament was indeed competent to legislate and provide for affirmative action in the interest of backward classes in educational institutions, provided it fulfilled some of the conditions imposed by the Supreme Court to ensure that the benefits of reservations reach the really backward classes.

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[13] This was the submission of Solicitor General G.E. Vahanvati before the Delhi High Court when a petition filed by Pan-IIM Alumni Association, seeking to challenge the validity of the 20 May memorandum issued by the government to implement reservations in higher educational institutions, was heard and admitted. See author's blog post, http://lawandotherthings.blogspot.com/2008/05/beginnings-of-mandal-iii-case.html.

PART III TRADITIONAL AND HOME CARE PROVIDERS: THE EDGE OF LEGITIMACY

Chapter 8

The Community Role of Indigenous Healers

An Exploration of Healing Values in Maharashtra

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Recent policies for mental health services[1] in India have tended to frame indigenous healers between two modernist but contradictory discourses. One imposes a 'service-providing' role to them, including them under the Mental Health Act, a medical Act which governs mental hospitals. The other, typified by a Maharashtra Bill on the eradication of superstition, completely denies them any validity, rejecting their knowledge systems as superstitious and unscientific. Neither of these two contradictory constructions adequately captures the community roles and healing practices of indigenous healers.

In order to better understand the position that indigenous healers and indigenous healing practices hold in the context of communities, we explore through an ethnographic analysis two indigenous healers from Tasgaon,[2] Maharashtra. Based on these two case studies, this chapter details various strands that characterise the relationship between indigenous healing and local communities. We focus on the micro-level exchanges

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[1] Following the death of 28 mentally ill persons in a fire that engulfed a dargah in Erwadi, Tamil Nadu, in 2000, the Supreme Court directed state governments to take measures to curb the human rights violations that were allegedly rampant at IHCs. There are suggestions to bring these centres under the purview of the Mental Health Act, 1987. In 2005, the Maharashtra government tabled a Bill outlawing 'superstitious practices' in society, viz., 'Maharashtra Eradication of Black Magic and Evil Practices and Customs Act, 2005'. The Act indexes a list of practices, including magic, witchcraft, sorcery, possession and trance.

[2] The name of the town has been changed in order to protect the identity of the healers.

between healer and sufferer, as it is shaped and influenced by their shared explanatory frameworks of well-being and illness, the diagnostic procedures, and healing rituals. At the same time, the chapter emphasises that indigenous healing is a specific universe of discourse, including design, scripts and actions; one which offers various lessons to modern systems of health care.

Background and Methodology

This chapter derives from a three-year field project[3] undertaken in nine districts of Maharashtra, to explore meanings attached to personal distress and healing experiences, with special reference to emotional health and recovery as they are mediated by indigenous healing. We interviewed four types of respondents: sufferers, caregivers, healers and medical service providers.

Multiple modes of data collection were undertaken, including in-depth interviews (43 healers, 57 service providers, 108 users and 75 caregivers), field observations and focus group discussions. Case studies were developed from the in-depth interviews. Approximately 25 hours of visual data were recorded, and photographs taken at various sites. Data was coded and recoded, before and after fieldwork. Some qualitative data was quantified using the software SPSS (Statistical Package for the Social Sciences); the rest was developed as content analysis spreadsheets.

With respect to indigenous healers, those with a high reputation of healing powers were chosen by reconnaissance and snowballing methods. They included healers who work at an individual level (n=11), catering to a small, localised community of sufferers, as well as large healing cults based upon the worship of a deity, *pir* or a *sant* who is attributed healing powers (n=32) (Table 8.1). Sites of healing included *mandirs*, *dargahs*, shrines and cults. All healers gave written consent prior to being interviewed.

Table 8.1 *Indigenous healing centres studied in Maharashtra*

Name of IHC	S.No.	Place
Babu Jamaal Dargah	1	Kolhapur
Balumama Devasthana	2	Admapur
Individual healers	3	Tasgaon
	4	Trimbakeshwar
	5	Mumbai
Kalubai Mandir	6	Wai
Katwan Khandoba Mandir	7	Tasgaon
Khwaja Kabir Dargah	8	Nandre
Mahanubhav Matt	9	Phaltan
	10	Maujesukene
	11	Gangapur
Malik Rehan Dargah	12	Vishalgad
Mirasaheb Dargah	13	Miraj
Mirawali Dargah	14	Tasgaon
Sadal Baba Dargah	15	Pune
Sailani Baba Dargah	16	Buldhana
Seshrao Maharaj	17	Shirpur
Sitaram Maharaj Mandir	18	Kharadi
Suvarta Church	19	Tasgaon
Vineyard Workers Church	20	Pune
Zalicha Dev	21	Jalna

Healers in our study were mostly male, with only two being female. Most healers (35) were married. Of the 43 interviewed, only a third (13) came from forward castes. Healers typically came from lower and lower middle class, and deprived castes, with more than half of those interviewed earning less than Rs 3,000 a month, although two healers were from the upper class and cultivated clientele from the business class. Of the 43, 27 (63 per cent) hailed from rural areas, while 16 (37 per cent) came from urban areas.

A majority of healers had some kind of basic education, ranging from primary to high school, but five were illiterate. Among the 14 who discontinued their studies, poverty was a major factor. Nonetheless, 33 out of the 43 healers owned their own pucca house. Most had multiple sources of income, including agriculture, small businesses and unorganised work. More than half were dependent upon their healing function as an income source, either through money from the healing institution, personal earnings from healing, or alms given by the devotees.

A main finding of our larger study was that the healers' socio-economic background (Table 8.2) was similar to that of the community they served. In addition, we found that these indigenous healing sites served a core healing function, upturning common myths that describe such sites as being a cultural curiosity, or otherwise plainly predatory upon people's gullibility. This is an important finding, especially considering the poor quality of mental health services presently available in the country.

Table 8.2 *Types of healers and their characteristics*

Categories	Services offered	Reported source for healing work	Description of healing
1. Possession	Problem-solving Mediumistic activities at shrines of healing deities or saints	Divine grace	Healing through entering trance, emptying/erasure/forgetfulness of self, giving up voice, amnesia, deity possession (being inhabited by a deity), taking *sawaal (answering questions)* and delivering the 'deity's word' on people's problems
2. Clairvoyance	Predictions	Regular performance of intense *sadhana* (ritualistic and prayerful meditation); skill in divination methods; Gift, talent or aptitude	Healing through use of personal agency and skill in delivering intuitive knowledge (*Siddhi*)
3. Occult practices	Individual healers or shamans providing exorcism, combating witchcraft, evil eye and black magic May be attached to	Traditional knowledge, inter-generational practice, personal skill	Ritual engagement with the spirit, investigating its history and background, its causation, manifestation and impact, engaging the spirit in expressing its unfulfilled pains and desires, organising the means for the spirit's wish fulfilment, finding ways of willing the spirit to leave the

	shrines of local healing deities		sufferer
4. Religious Technique	Individual healers offering prescriptions for ailments sometimes attached to shrines	Formal scriptural texts, Hindu or Islamic Learning a technique *(vidya)* Faith in pre-ordination	Study and interpretation of sacred texts and finding suitable charms, rituals, mantras etc. for relief, practice of astrology
5. Social service	Secular healers (not falling back upon a notion of the 'sacred' in their practice)	Social work and an ideology about doing service to the community; use of herbs, native medicines	Looking after them, feeding them, tending to their difficulties and troubles, taking care of abandoned patients, giving medicines

Abbaji and Kaka

Two healers were selected for the in-depth case studies used in this paper. Both are based in the western Maharashtrian city of Tasgaon, and represent two disparate healing discourses. We hope to demonstrate the heterogeneity that marks this sector through these two cases. While one is based in Brahminical Hindu practice, centred around a charismatic healer, the other practice follows Koranic prescriptions in order to deal with 'spiritual disorders'.

Asif Ahmed[4] (alias Abbaji), a 62-year-old healer residing in Tasgaon, has a small clinic *(davakhana)* in the heart of the city, and has been a healer for the last 39 years. He has been felicitated by the municipal corporation of Tasgaon for his contribution to the community with two awards: the 'Ideal Citizen' award and the *'Dalit Mitra'* award. Abbaji specialises in healing sickness pertaining to the 'spirit' *(ruhani bimari)* by interpreting *aayats* (verses from the Koran).

Purushottam Sakhalkar (alias Kaka), also based in Tasgaon, is associated with *'Katwan Khandoba Devasthana'*, a temple

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[4] The names of both the healers (and their aliases) have been changed in order to protect their identity.

dedicated to Khandoba, delivering healing services in the community for 25 years. Kaka is 50 years old and belongs to the Maratha caste. He is an employee of the municipal corporation of Tasgaon and lives with his wife and son in a two-storeyed house. While Kaka is a full-time government employee and works in the municipal corporation of Tasgaon, Abbaji is a healer by occupation. Both of them have graduate degrees. Their reported monthly incomes range between Rs 5,000 and Rs 8,000.

Abbaji and Kaka both subscribed to a well-developed causal framework of client examination, diagnosis and prescribed treatment. Abbaji attributed his prowess to the blessings of Sulaiman Paigambar, commander of the spirit world, and to the healing powers of the Koranic *ayats*. The Koran and *Ilm-e-Ramal* (a text on stars and planetary movements) describe the procedure of healing from spirit related illnesses. Thorough knowledge of the Koran and *ayats* is an important prerequisite for becoming a healer.

Kaka attributes the problems that people face today to their moral degradation. His curative framework required the fulfillment of prescribed family and religious obligations. Failure results in the deity's wrath, manifested as illness or domestic misfortune. In curing spirit-related illness, Kaka uses the *vidya* of 'jaaran, maaran, uchhatan', which is prescribed in ancient Hindu texts, specifically in order to exorcise evil spirits or cure cases of witchcraft.

The construction of the healers' image in the eyes of the sufferers is also a vital influence on the healing interaction (Kennedy 1997; Kakar 1987). The healer's personality plays a decisive role in inspiring hope and strength within the sufferer (Harding 1975). The charisma surrounding the healer is also complemented by a myth of origin of the healing tradition or the healer. A rough patch in Kaka's life had drawn him close to the arena of spirituality, as he started frequenting the Khandoba temple for prayers. Kaka received his 'diksha' (knowledge) from *Tulajinath Baba*, his spiritual Guru, at whose behest he started his healing work. For Kaka, it is a combination of aspects like his appearance, his ritual manifestation and the centrality accorded to him during many rituals, which enhances the force and magnetism of his personality.

Abbaji inherited the healing legacy from his ancestors. One of his ancestors was blessed with a divine vision while praying; following which he served a period of rigorous penance and gained divine powers. Since then, the legacy of healing was established in their family. Legend has it that villagers once came to him with the problem of lack of food. He prayed over two *rotis,* and then the whole village ate their stomachs' fill from those two *rotis.* By virtue of his birth into a family which has been blessed by this legacy, Abbaji was eligible to become a healer. In stark contrast to Kaka, the role of personal charisma is visibly lower in Abbaji, who has the weight of tradition and divine legacy of healing of 142 years behind his practice.

Healing as a Central Community Function

In establishing relationships between sufferers and healers who focus on 'problem solving', a match in role definition and expectations between sufferers and healers is the first step. This matching of roles and expectations, and the relationships it engenders, forms the basis for the healers' interface with the larger community. A few cases of people with 'problems' presented to these healers elucidates this point.[5]

> *Abhijit Sali was a young man from Tasgaon, who had come to Kaka. Initially he used to work in a private company, but his heart was not in this job, since he wanted to start a business of his own. After leaving his job, when he did start a business of his own, it did not take off. This created tension in his family. There were constant quarrels, which vitiated the home atmosphere. He had no mental peace.*
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> *Asha Shah, a 50-year-old woman from the Marwadi community, came to Kaka because of terrible headaches that she had been suffering for the last 15 years. She was not getting along well with her husband, giving rise to constant tension, which exacerbated her headache.*

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[5] These cases have been taken from the interviews conducted with people who had come to Kaka and Abbaji for healing. The problems are presented as they were reported by the interviewees. The names of the interviewees have been changed to protect their identity.

Five years ago, her daughter also developed a backache problem and could not sit. The atmosphere at home was destroyed. She suspected witchcraft by her neighbour.

Dhanashree Mutha had come to Abbaji for an unexplained problem. Six years ago her husband had died, and since then she had been suffering. Sores started appearing on her hands, gradually spreading all over her body, including her face and other exposed parts. It was very painful for her as the sores used to burn, itch and bleed. Her eyes used to burn and her face had become unrecognisable. Abbaji diagnosed her for witchcraft.

Shantidevi Gupta had come to Kaka for her daughter's problem. Her daughter had given birth to a son three years ago. From the day of his naming ceremony, her daughter had been seeing a man and a woman in front of her. She used to get fever and had started babbling strange things at times. She used to feel that someone was sitting on her chest and trying to strangle her. She also started suffering from body ache and general fatigue. All this caused a lot of tension and worry to Shantidevi, and she had come to Kaka to get her daughter released from evil spirit.

Mr Shroff was a regular client at Abbaji's clinic. His family was associated with Abbaji for the last 20 years. He visited him for protection against mishaps and evil. He suffered a heightened fear of unknown things. He was constantly anxious that his business would recede. He wanted his anxiety to reduce. As he put it, 'I go more for preventive purposes than for a problem. I go there for my well-being.'

In these experiences, there are physical and psychological dimensions, which are individualised and diverse, ranging from strange behaviour to emotional suffering, to bodily pain and weakness of different degrees and qualities. Sufferers came with concerns spanning their life, including social, financial, domestic issues, relationship problems and other emotional concerns. There is often no distinction made between a health 'problem'

and one's emotions and life experiences surrounding it.[6] However, the definition of a 'problem' may still be specific, having the quality of an important life event or process usually disruptive of daily life. These qualitative findings were echoed by findings from our larger quantitative survey.

Though faith is an important part of healing and well-being, a phenomenology of 'evil', linked to personal and/or communal well-being, also figures significantly in these narratives. The 'problem' then becomes a type of expression of it. Themes of interpersonal jealousy, malice and ill-will are starkly evident, as in the cases of Dhanashree and Shantidevi.

Both healers traced reported illness to witchcraft and evil spirit possession. Within this framework, not only is witchcraft/ spirit possession *not* a mental illness, but mental illness, physical health problems, and a host of other problems (*traas*) are a consequence of witchcraft/spirit possession. In our extensive field work, 'mental illness' was not a presenting problem. Witchcraft was. Witchcraft manifested as causing great economic loss, ruination, mental problems, strange behaviours, talking and babbling, fear, violence, neglect of work and family, wandering, running away, nightmares, withdrawal, suspiciousness, strange visions, and emotional turmoil.

In our larger study, we found that if communities equated witchcraft with mental illness, they would choose health care, given the awareness that mental illness required a health providers' help. But since the cultural perception was that witchcraft caused mental illness, their choice of going to places where witchcraft cures were available was logical. A fit between the healers' and the sufferers' explanatory models is evident here. Our study clearly showed a pattern that, for medical problems, health care was sought; and for psycho-social-spiritual problems, local healers were approached.

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[6] Literature on medical anthropology shows how communities define states of health and ill health in a dynamic way, as equilibrium between individuals and their physical, social, moral and spiritual welfare (Bannerman 1982). Health is located within a macrocosm involving self, community, environment and various human and non-human (both sacred and evil) agents. Indigenous systems similarly address an inclusive range of concerns, rather than being tightly defined as physical disease or mental illness (Kapur 1979; Harding 1975). The profile of problems presented to these healers reflects clearly this dynamic conceptualisation of health and illness.

Corresponding to the users' conceptualisation of ill health, their expectations are broader than 'curing a disease symptom'. Healers were seen as more than doctors. This explains why sufferers like Mr Shroff visit the centres for many years continuously. Well-being is not just about relief from ill health, but also includes an intent or resolve to stay well; reassurance; building protection from pain; and planning long term health. Well-being is tightly bound to people's interpersonal and community contexts, and the perceived disequilibria in it. In this context, spirituality — or retrieving the connection with something experienced as sacred — and restoration of well-being are coeval. Widely reported in our larger study is the experience of being healed after receiving faith healing, leading to new subjective insights on personal well-being, over and above objective clinical indicators.

Just as community members did not define healing in narrow health terms, healers too did not narrowly define themselves as doctors. Abbaji did not identify himself as a clinician, but he said he served people in order to reduce the level of their mental distress. Kaka rejected the labels of *hakim*, *tantrik* or a *baba* that were given to him, defining himself as an agent of social change who contributes to the betterment of society, by inculcating a moral-spiritual outlook. 74 per cent of the healers interviewed said they did not think of themselves as doctors, while only 21 per cent agreed that they were a type of a doctor. Healers identify themselves more with broader human goals of life, and of facilitating a sacred connection, if not spiritual realisation (*marga darshan*), of which well-being is one consequence.

The examples from our study are consistent with earlier research on pathways to care (Goldberg; Huxley 1992; Kapur, 1979), which suggests that accessing indigenous healers is a matter of preference, rather presumed 'lack of awareness'.[7]

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[7] An overwhelming number of medical service providers interviewed during our research (n=57) agreed that lack of awareness about mental health issues was a major reason for the community accessing indigenous healing services. There was a general consensus about that spirit possession or trance was symptomatic of neurotic or psychotic disorders, and in the absence of 'scientific knowledge' about mental illness, sufferers were misled by 'superstitious beliefs and tradition' to indigenous healing practices.

Sufferers access places where they can express their problem as they experience it, where they sense a match between their causal models of illness and the models prevalent in the healing space; places which will address cosmological and personal, existential issues; where they will not be forced to directly confront their problems at the individual level and they can depend on divine/collective mediation.

The success of the healing function and exchanges hinges on the extent to which users identify with healers' causal explanatory models of health and illness (James 1986; Helman 2001). Kleinman and Sung (1979) contend that the popularity of indigenous healers is based upon the fact that their explanations are personally and socially meaningful to the sufferer. Framing the person's distress within a shared language, making it instantly recognisable to the sufferer, and helping them gain personal control over the situation, are central to indigenous healing. Indigenous healing centres acquire efficacy in the sufferers' eyes by identifying a person's suffering in cultural and religious terms that they closely relate with.

How Healers Heal: The Micro-healing Environment

Both healers, Abbaji and Kaka, agreed that mental strength, courage and a strong moral character are essential characteristics of a successful healer. Qualities like complete faith in God, maintaining ritual purity, in-depth knowledge about healing rituals and practices, also constitute attributes of a good healer. Kaka believed that sensual pleasures and spirituality are diametrically opposite to each other; hence a healer has to forgo all pleasure of the senses to serve as a spiritual ideal for his community. These ideas about a 'good healer' are commonly shared among the indigenous healers' community in Maharashtra (Table 8.3). Although knowledge about healing practices is one of the good qualities, it is not the topmost.

Table 8.3 *Characteristics of a good healer — healers' perspectives*

Characteristic	Frequency (total no. of healers: 43)	%
Implicit faith	37	86.05%
Mental strength	36	83.72%
Maintaining ritual purity	36	83.72%
Knowledge about healing practices	34	79.06%
Moral character	33	76.74%
Ability to be possessed by deity	10	23.25%
Other	6	13.95%
Other descriptive responses		
No such special traits	3	6.98%
Love, empathy and compassion	3	6.98%
Spiritual power	2	4.65%
Special psychological powers	2	4.65%

In Kaka's view, healers like him had to present an ideal for the society. Followers and devotees had certain expectations from them, and it was their responsibility not to let them down. Being a healer who engages in a personal interaction with each of his clients, he believed that protecting the trust and confidence that his clients placed in him was of utmost importance. Helping his clients and seeing them getting healed was the source of unlimited energy for him, said Kaka.

Both healers admitted to taking efforts to enhance and protect this healing legacy, be it Kaka's rigorous *sadhana* or Abbaji's thorough study of the Koran. But the healers abstained from taking credit for their healing agency. Kaka attributed his success as a healer to the tremendous faith that people placed in him and in God, their service *(seva)*, which created positive energies in that space, and to his spiritual guru.

This illustrates the delicate balance that is maintained in the context of the healers' position vis-à-vis community. Recognition, reverence and high esteem for the healers' powers are forthcoming from the community. But it is so, precisely because of the humility, surrender before the sacred and the detachment shown by the healers towards their healing agency. The traditional healers fit the community's archetype of a spiritual leader, who is touched by certain cosmological powers, personifying ideals of purity and character. He is a balance of authority, protection and benevolence, all couched within the

cosmological imagination of that community. That well-being will flow from such presences in the community is accepted.

In all the sites of our study, we found healing to be programmatic and a performance, involving detailed and precise design, as well as use of language, body and ritual. The design flows from local knowledge systems, including local art forms and other social practices. Other than frank embodied experiences of trance and possession, bodily routines include prescriptions about food and fasting, physical movement (like circumambulation), cleansing, and using diverse sensory experiences, including the visual, auditory and olfactory.[8] Spatial and temporal dimensions are designed to suit the process.

A healing setting is especially precise in places where possession, trancing or exorcism happens. Spatial arrangements for the trancers, the community, the healers, the mediums, the drummers, and other agents in the healing process are apportioned based on their respective roles in ritual healing. Ritual meaning is not necessarily found in language alone. Faithful repetition of ritual practice by the healer, as well as the user, is expected for healing objectives to be achieved. The communal nature of healing makes it a public event, and not a private state. These elements are evident in the case of the two healers described in this chapter.

Abbaji and Kaka's practice involved a clearly demarcated method of diagnostics. Though Abbaji diagnosed through a Koranic method, the predominant method of diagnosis was non-cognitive, namely through exorcism sessions. Incense was held in front of the client by Abbaji's attendant, as the holy smoke manifested the evil spirit. A community awaited the 'presence' (*hajeri*) in palpable silence. And Abbaji prompted the spirit to appear by swearing in the name of various deities.

Exorcisms were unnervingly intense, wherein the spirit inhabiting the person made him/her scream and thrash about, and the community restrains the spirit/person. Once the spirit manifested, Abbaji began naming the spirit, questioning it about

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[8] In the Balumama cult from Admapur, dance is used. Drums, cymbals, bells and other percussions local to Maharashtra and the region are routinely used in the *aartis*. Songs are an important part of the centres' repertoire of devotion and prayer.

the reasons for inhabiting the victim, its demands and resolutions. There was a musical flow, pause and rhythm, as well as logic, to the rapid fire interrogation delivered in even tone.

Sufferer (a young girl screaming loudly): Leave me!!

Abbaji: Moula Abbas ka vaasta hai! Moula Abbas ka vaasta hai! (I swear to you in the name of Moula Abbas)

Sufferer: (Still screaming) Leave me!

Attendant: Who is this?

Sufferer: It is a woman.

Abbaji: It is a woman. Is she alive or is she dead?

Sufferer: She is alive.

Abbaji: Alive. Is she from the same caste or an outsider?

Sufferer: An insider.

Abbaji: Insider. Why has she gotten behind the girl?

Attendant: Why has she gotten behind the girl? What are the reasons? Come on now, speak up!!

Sufferer: (Screaming loudly) Leave me!!

Attendant: Don't scream!

Abbaji: Admit. I swear to you in the name of Sulaiman Paigambar! I swear to you in the name of Sulaiman Paigambar!! The reasons?

Attendant: (After listening to what the girl whispered in her trance) for reasons of property...

Abbaji: Okay.

Attendant: Whose property is it? Is it the girl's property?

Abbaji: What was done for the property?

Attendant: (After listening to what the girl whispered in her trance) The victim has been fed something...

Abbaji: Who all have been fed?

Attendant: Who all have been fed? Only the victim has been fed.

Abbaji: Where was it (whatever was fed) gotten?

Attendant: Where did you get the food? Where?

Abbaji: I swear to you in the name of Paigambar...

Abbaji persisted in eliciting the information that he needed. The point of contention (property matters) for the client had been revealed, as also the way of affliction. There was a clinical nonchalance in Abbaji's demeanour as he effectively conversed

with, persuaded, intimidated, threatened and exorcised the possessing spirit. This is how the exorcism eventually ended:

Abbaji: Just tell me, are you going to leave the girl or not? Speak up!
Attendant: Are you going to go or not?
Sufferer: Yes, I will.
Abbaji: Will the girl suffer after this?
Attendant: Will the girl be troubled after this?
Abbaji: The girl should not suffer in any ways till then, do you get it? And her family members also should not be troubled.
Abbaji: Get lost now!!

Abbaji prepared the Koranic healing *ayaats,* thus conveying reassurance and control to the sufferer as well as to the community, reinforcing their faith in him as a healer. It also represented a closure for her and her family, as the possessing spirit was exorcised conclusively during the process.

At Katwan Khandoba, where healing was more cognitive and based on sacred Hindu texts, the healing sessions began on Sundays. First timers filled out a form, recording their socio-economic details, history, nature of problem and other details. Many of the questions Kaka asked sought to confirm details about a person's family history or ritual obligations, which he already knew through his powers. Kaka also probed about domestic conflicts, or about conditions surrounding marriage etc. His delivery style was firm and, at times, even patronising, but not intimidating, the intensity broken by humour and laughter. Sufferers sat on the floor at Kaka's feet, while he sat on a throne-like chair, especially used for these sessions. Kaka spent a considerable amount of time with first timers, with each interaction lasting about 20-25 minutes. Through his entire stance, the way he leant forward attentively towards the sufferer, the pregnant pauses as he contemplated over the question of a sufferer, the knowing smile he sometimes flashed at them, he conveyed to them a sense of power and reassurance, as well as a sense of being totally knowing and caring.

Kaka: Family goddess?
Sufferer (a woman): Goddess of Tuljapur

Kaka: There is a constant problem in the house?

Sufferer: Yes

Kaka: There is no happiness, no satisfaction. How many children do you have, woman?

Sufferer: Two sons, two daughters

Kaka: Sons are also married. Your daughters-in-law do not take good care of you, am I correct?

Sufferer: Correct. The younger one does not look after us, the elder one does.

Kaka: The elder one also does not take good care, is it?

Sufferer: No, the elder one takes care, the younger one does not. She is the one.

Kaka: She does not visit you. It's been going on like this, hasn't it?

Sufferer: For four years

Kaka: Does not come, does not meet you... she does not let your son also meet you!

Sufferer: No

Kaka: (Laughing a little) Your son, whom you nurtured since he was a child, is now separated from you. Is it correct?

Sufferer: Correct...

Kaka: After marriage, have you performed any *puja* /worship rituals?

Sufferer: Yes

Kaka: What have you done?

Sufferer: Have worshipped Veerbhadra, Devi...

Kaka: What else?

Sufferer: And Devi. Haven't worshipped Khandoba.

Kaka: Haaaaaah!!

Sufferer: Haven't worshipped Khandoba.

Kaka: That's what I'm asking! Khandoba is a deity in your house, isn't it?

Kaka gently and empathically diagnosed the woman's distress, by framing it within the mother-son relationship. This signified validation of her feelings, which was probably one of the significant things which she was seeking in her consultation with the healer. At the same time, he took care not to dwell too much on her distress in personal or interpersonal terms, immediately externalising it in terms of non-fulfilment of family

religious duties, thus placing the responsibility back on her. Here too, the healing is public rather than private.

The healing propensity of indigenous healing systems is attributed to several factors, like arousal of faith, complete emotional commitment of the sufferer, affirmation of shared beliefs; the symbolism entailed in healing rituals and their dramatic quality having effects akin to therapeutic techniques like placebo, catharsis, suggestion, etc. (Kleinman; Sung 1979; Kleinman 1980; Jadhav 1995; Helman 2001). The healing process has also been seen as symbolically representing certain values, emotions, social relationships and normative codes, which are a part of the participant's inner world as well as their external social environment (Glik 1988; Csordas 1983; McGuire 1983; McCreery 1979).

The most common ritual prescribed by Abbaji entails using the Koranic *ayats* to cure the client's afflictions, which Abbaji diagnoses as originating from earth, water or air. The elemental forces in nature are causative agents of ill-health and recovery. Abbaji writes the healing verses on paper in special ink. Depending on whether the affliction originates from earth, air or water, the client is advised to burn and bury the *ayat*, burn and smell it, or immerse it in water and drink it. Sometimes, if the afflicting evil power is inanimate, Abbaji writes its name on a paper and advises the client to burn or bury it far away from his/her residence. Abbaji also prescribes preventive rituals to ward off the evil eye. Preventive objects mentioned in the Koran are tied to the door or at the entrance of the house, or at a place where it will protect the client from evil forces. The extent of the harm done to the sufferer is measured through a ritual in which the sufferer's height is measured with a string prayed over by Abbaji.

There is a wide assortment of rituals that are prescribed to the sufferers at Katwan Khandoba. A significant healing role is accorded to turmeric (*bhandara*) and lemons, consumed or applied. Wearing the holy thread (*vastra*) around one's neck is another compulsory initiation rite, signifying the person's entry into the religious and spiritual community of Katwan, and into a pledge or resolve of healing. Kaka might give the sufferer leaves of various trees like mango, banyan, *oudumber*; different fruits and dry fruits; roses or cloves and cardamom. All these

are mediumistic, being imbued with the deity's healing and protective powers.

The diverse types of problems addressed by these healers, the shared explanatory frameworks of illness and misfortune, the diagnostic process, and the healing rituals — it is possible to look at these various aspects as constituting parts of a well-structured healing process. This process encompasses not just the need for alleviation of external signs of suffering for the afflicted individual, but also incorporates his/her need to allay the accompanying emotional distress. Hence, it is not a surprise that these aspects work in tandem with each other to provide sufferers with a sense of control over their situations, resulting in surrender to the reassuring aegis of the healer and the healing deity. Indigenous healers typically include a variety of these aspects, and healing interactions offer community members these components in an integrated, and often stylised, fashion.

Conclusion

A nuanced approach that appreciates the centrality of indigenous healing in the larger socio-cultural context of well-being and community life is critical. Indigenous healing systems are mistakenly seen in a homogenous light, completely obscuring the internal variations that exist between different systems. Abbaji and Kaka, as two case studies, significantly illustrate the variety of healing systems that are contained within the larger category of indigenous healing.

Our case studies also demonstrate how local indigenous healers provide the transcendental and existential aspects of health and well-being. The efficacy of this healing must be examined in terms of its own conceptual as well as contextual location, and not entirely through standards applicable to modern medicine or psychiatry. It would be a folly to claim indigenous healing as a component of the health system, and to proceed to use standards reserved for medical health care provision in order to assess its efficacy.

The pitch of the healing interaction, and the roles that healers fulfill in the community, point towards the need to reconceptualise notions of health and ill-health in modern health care on the basis of their relevance from the community's point

of view. Aspects like the healing function, shared explanatory frameworks, methods of diagnosis and healing rituals, the projection of the healer's image, myth building, and the healers' perceptions of their role, all work in tandem with each other to provide sufferers a sense of control over their suffering, resulting in surrender to the reassuring aegis of the healer. Healing, in its broadest sense, would include these aspects, and indigenous healing systems often offer community members these components in an integrated fashion.

Indigenous healers also offer lessons on healing values to modern systems of care. We believe that indigenous healing sites provide a conducive psycho-social environment, within which the internal lives and experiences of peoples and communities can be enacted and experienced in a non-alienating and personally engaging manner. From the 'healing' point of view, these aspects give an alternative picture about therapeutic values and therapeutic ambience, and about notions which must guide an empathetic doctor-patient relationship.

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Chapter 9

Traditional Orthopaedic Practitioners' Place in Contemporary Health

A Case Study from Southern India

Unnikrishnan PM, Lokesh Kumar HP and Darshan Shankar

T raditional orthopaedic practice (TROP) is a key domain of local health knowledge. Despite the fact that it is common in large parts of rural populations in developing countries, TROP is neglected in official health care programmes for a variety of social, economic and political reasons. Consequently, there is lack of sufficient data on health seeking behaviour, demographics of traditional orthopaedic practitioners, and the quality, safety and efficacy of their practices. A study was conducted in two states of southern India to explore some of these aspects of traditional orthopaedic practice and practitioners. We document some key findings from the study till date, and reflect on broader questions around the role of this popular and varied group of health providers.

According to the World Health Organization (2003), 'Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.' Unlike many countries which possess only oral traditions of health knowledge, China and India have two types of traditional medical systems; one, codified systems with written literature spanning over 3-4 millennia, as in the relatively formal systems like Ayurveda or traditional Chinese medicine, and the other, more localised, non-codified, folk traditions, which are far more diverse since they are practiced by different ethnic communities and draw from varied local ecosystems.

In industrialised countries, adaptations of traditional medicine are termed 'complementary' or 'alternative' (WHO 2003). Almost half the population in many industrialised countries now regularly uses some form of traditional/ complementary and alternative medicine (United States 42%; Australia 48%; France 49%; Canada 70%), and considerable use exists in many developing countries (China 40%; Chile 71%; Colombia 40%; up to 80% in African countries) (Bodeker; Kronenberg 2002). Many governments in Africa, Asia and Latin America have incorporated traditional medicine practices to help meet their primary health care needs.

Traditional orthopaedic practices in developing countries are found predominantly in rural areas, and include a spectrum of practices such as management of fracture, dislocation, and primary care of patients suffering from chronic musculoskeletal conditions like arthritis, post-polio residual paralysis and congenital deformities. These practices often involve a special understanding of anatomy, such as the concept of vital points in the body (as in *Marma kalai* in India), and also special types of massaging techniques and herbal medicinal preparations to promote the healing of wounds and to strengthen bones. In many developed countries, these practices have been formally recognised, as in the case of Osteopathy and Chiropractic.

A recently published review of traditional orthopaedic practices by Burford et al. (2007) describes the global distribution of musculoskeletal disorders, and the presence of traditional orthopaedic practices in the developing world (this volume also introduced the acronym TROP). Although chronic disease is one of the highest global health priorities, with 21 million DALYs (Disability Adjusted Life Years) attributed to musculoskeletal disease (WHO 1999), health planners widely accord greater priority to service delivery, focusing on other conditions such as endemic disease, family planning and immunisation. Resultantly, in many developing countries, modern orthopaedic care is available only to a limited number of people living in urban areas. For example, Sudan, a country of 24 million people, in 1996, had only six modern orthopaedic surgeons, of whom four were practicing in Khartoum (Burford et al. 2007).

In a recent editorial written in the Indian Journal of Orthopaedics, Anil Jain (2007) delineates the Indian situation.

There is a wide contrast within health facilities available in the country — at one end there are the well-equipped, corporate hospitals in metropolitan cities, performing state-of-the-art surgeries; and at the other end, often, a complete absence of orthopaedic care facilities at the village, taluka and tehsil level. While there are orthopaedic surgeons in government-run district hospitals, in the context of the lack of infrastructure, their role as specialists remains limited. Jain also mentions that there is high techno-centricity in orthopaedic management, and that educational programmes in orthopaedics are usually modelled to address a high-end health care market. For example, while progress in low-tech interventions such as closed treatment of fracture is not significant, techniques like joint replacement, arthroscopy and spinal instrumentation have seen tremendous developments. Private facilities offering such specialised procedures are flourishing, and costs of orthopaedic care escalating (Jain 2007).

In this prevailing context, where both the public and private formal health care sectors are failing to cater to basic orthopaedic care needs, the large numbers of traditional orthopaedic practitioners have a potential role to play in India and other developing countries, particularly in the rural areas.

Traditional Orthopaedic Practices (TROP) in the Indian Context

It is estimated that there are approximately 60,000 traditional orthopaedic practitioners in rural India (Shankar 2006). According to Government of India Census (2001), there are close to six lakh (600,000) inhabited villages in India. This means that for every ten villages, there is one orthopaedic practitioner. Their practices include fracture and dislocation management, *marma chikitsa / varma kalai* (understanding and management through vital points in the body, as in acupuncture), management of injuries and their complications, management of congenital anomalies like club foot, treatment of post-polio paralysis and musculoskeletal disorders using different types of oil therapies, and many more to be explored. This knowledge has been passed on through centuries of practice from one generation to another. Mostly, the knowledge is inherited as a family tradition, and in some cases, it is taught as a teacher-to-student tradition through informal apprenticeship.

There is a vast array of literature available on the subject in the Indian subcontinent, as it is an important aspect of the Ayurveda and Siddha medical systems. In the 10th century BC, the writer Susrutha described 12 types of fracture, six types of dislocation, and the steps involved in treatment — traction, manipulation by local pressure, opposition and stabilisation, and immobilisation under the specialty of Ayurveda, called *salya tantra* (surgical management) (Radhika 2000). Elaborate sections on topics such as *marma* are also available. Several medicinal plants are used for preparation of splints, poultices, medicated oils, etc. in India.

There are many specialised and renowned traditional orthopaedic centres in southern India. Some examples are the Puttur bone-setters in Andhra Pradesh, Telungupalayam family, Olakkode Asan family and Mamsapuram tradition of Tamil Nadu; CVN Kalari or Muttikulangara families in Kerala; and Ankola family in Uttara Karnataka, which have acquired a *de facto* status of 'geographical indication' of origin of these practices. These centres are catering to large number of patients, both from rural and urban areas. In the southern districts of Tamil Nadu, *marma* (management through vital points in body) tradition is common. In Kanyakumari, there is even an association of *marma* practitioners, with a good number of healers as members. In Kerala, bone-setting is also part of the tradition of martial arts *(kalari),* which is popular in the state. Typical conditions and injuries treated by a *kalari* master are attributable either to martial-related activities (injuries from exercise or external shocks/wounds) or pathological conditions affecting one's ability to exercise (weakness or muscular complaints) (Zarilli 2006). There are also centres based on classical knowledge of Ayurveda or Siddha that are specialised in orthopaedic management, with excellent facilities. Many Ayurveda and Siddha colleges now have specialised departments of *salya tantra,* with experts on orthopaedic management.

A Study of TROP in South India

Though there are some studies on traditional bone-setting practices, the medicinal plants used in them and their pharmacological properties, there are very few studies nationally or internationally on traditional orthopaedic practitioners and

their contribution to the health sector. The services they provide receive scant attention in official public health spheres, as is the case with many other specialties of traditional knowledge. The few sociological and anthropological studies on these practices that exist do not reflect the clinical safety or efficacy of these practices, nor the extent of their reach or contribution to public health goals. The socio-economic conditions of the practitioners, methods of training and practice, lineage, public support and social legitimacy, and their prospects for the future, are other aspects which are poorly explored.

With this context in mind, in order to understand the status of traditional orthopaedic practitioners in south India, the Foundation for Revitalisation of Local Health Traditions (www.frlht.org), a non-government organisation based in Bangalore, initiated a pilot project in 2002. The main objective of the project was to make an inventory of traditional orthopaedic practitioners in selected states of south India. Another objective was to undertake comprehensive clinical documentation of selected traditional orthopaedic practitioners, and the cases managed by them, in order to understand their clinical safety and efficacy. Some of the deeper questions that drove this research were — What makes people approach traditional orthopaedic practitioners? How safe and effective are these practices? What makes these practitioners continue their tradition? What kind of future do they envisage for themselves and their profession?

The inventory survey looked at the following questions: total number of traditional orthopaedic practitioners in the two states of Tamil Nadu and Karnataka, current status of TROP in these states (whether spreading or eroding), the area covered by the healer and his/her successor in their practice, and their social, economic situation. Clinical practices are discussed later.

For the survey, the data collection tools were structured questionnaires prepared based on above questions. The study adopted a purposive and snowball sampling method by identifying practitioners through local non-governmental organisations in respective localities. Field volunteers did the data collection through individual interviews of practitioners. Data were verified and cross checked at different levels. Public opinion about the practitioner was also collected in order to

understand the popularity of the healer, and the confidence and experience of lay people in their nearby areas.

An Unbroken Tradition

Between 2004 and 2007, a total of 549 healers were interviewed from Tamil Nadu (n=410) and Karnataka (n=139). Maximum number of vaidyas documented was in Thiruvannamalai (n=104) district in Tamil Nadu. Similarly, Shimoga district had the maximum number (n=65) of healers in Karnataka. Some of the important findings are summarised in the pages that follow.

A significant aspect noted during the study was that the traditional orthopaedic practitioners have high heterogeneity in their socio-economic status and practice. Practitioners belong to a wide range of classes, starting from those who practice in humble situations (even on the streets) with no infrastructure or facilities, to healers who are well established, having nearly 30-40 bedded hospitals with good infrastructural facilities, including x-ray units, technicians etc. There are physicians belonging to a long lineage, even the tenth generation, against many who are first-generation healers. With respect to their clinical management skills, there are healers who manage complex conditions, in contrast to people who just treat sprains. There are also significant differences in the way they practice, their fee structure and their overall attitude towards the profession. For example, two prominent vaidyas interviewed in our survey at Kanyakumari and Coimbatore belonged to a class of healers that can manage quite complicated conditions. They have well-established hospitals, and manage conditions such as club foot, post polio paralysis, scoliosis and even compound fractures.

Investigators observed that the vaidya of Kanyakumari was able to handle with precision, complicated forearm fractures (both radius and ulna) with closed reduction, a condition generally managed through surgical intervention in contemporary medicine. We noticed that his management was excellent in such cases, with no noted complications.

Similarly, the Coimbatore vaidya's treatment of clubfoot is so well known that people from all over India, and abroad, visit him for treatment. There are also expert physicians, who are

not linked to institutions but handle very complicated cases, the vaidya Reddy (from Shimoga) was one such.

Traditional orthopaedic practitioners were categorised based on four areas of specialisation — fracture management, massage therapies, *marma* practitioners, and practice of fracture management along with other general practice. In Tamil Nadu, most healers documented in the study did fracture management. But many of them also treated conditions like rheumatic disorders, treatment through chanting of mantras, poison treatment, treatment for tumours, steam treatment, massage, and other external treatment techniques as mentioned in the 'others' category in Table 9.1.

Table 9.1 *Traditional orthopaedic practitioners in Tamil Nadu, by specialisation*

Sl. No.	Specialisation	No. of healers
1	Fracture management	299
2	Massage therapies	21
3	*Marma* (vital points)	36
4	Others (treating general cases, including fractures)	54
	Total	410

Generally, among local healers, one would see a connection between the ethnic community of the healer and the specialty he/she practises. Specific worldview and belief systems related to that community are inherently linked to their practice too. For example, *Navidhars,* or the barber community, in certain locations in Tamil Nadu are experts in treating skin troubles. Similarly, *Kurubas* in Karnataka and *Konars* of Tamil Nadu, the shepherd or cattle-rearing communities, are experts in veterinary medicine. *Irula* tribes are known for their skills in treating poisonous bites. In the field of bone-setting, we did not observe dominance of any one such community. In total, 59 communities were recorded in Tamil Nadu as practicing bone-setting, with 39 healers belonging to the *Goundan* community. In Karnataka, a total of eight communities were recorded as practising bone-setting, and *Idigas* and *Vakaliga* healers were comparably more than the other communities. Another interesting fact is that unlike other branches, there are not many spiritual practices/non-material aspects noted in orthopaedics

area, though some general mantras (chants) were observed. Also, there were no specific days auspicious for the practice, unlike in other areas of traditional medicine.

Table 9.2 *Traditional orthopaedic practitioners — generational lineages*

Generation	Healers–Tamil Nadu	Healers–Karnataka
10th	01	–
9th	–	01
7th	05	02
6th	02	01
5th	13	04
4th	33	21
3rd	89	38
2nd	113	42
1st	19	21
No generation	135	9
Total	410	139

Theni district of Tamil Nadu has one family with practitioners in the tenth generation of the tradition. One of the healers, Vaidya K.Chinniah Gownder, aged 76, from Tamil Nadu, reported that he had experience of over 35 years. Similarly, in Karnataka, a healer belonging to the ninth generation was documented. Though it warrants further study, from the data it can be ascertained that complexity of practice has a direct correlation with the lineage, with more complexity being found with older lineage. We also documented a high proportion of first-generation healers (144 of the total 549), indicating the need to recognise 'practitioners of traditional medicine' as a subgroup distinct from genealogical 'traditional practitioners'.

We also asked certain questions related to the continuity of knowledge. In the long histories listed, has the tradition continued without any change? As it is not a written tradition and is largely oral, many aspects have been endangered. Some of the southern districts in Tamil Nadu, such as Kanyakumari, Thirunelveli, Virudhunagar, Theni and Madurai, boast of unique traditions like *marma*, a special way of managing injuries. A documentary on *marma* tradition telecast on national television (on the episodic programme Surabhi on Doordarshan) pointed out that healers who have in-depth knowledge of *marma*

tradition are rare today, indicating that the tradition is slowly dying. We also observed similar erosion of tradition in our documentation, though we noted some innovations that are being introduced by some healers.

Table 9.3 *Healers categorised by age group*

Sl. No.	Age group	Healers– Tamil Nadu	Healers– Karnataka
1	20-30	5	10
2	31-40	83	40
3	41-60	214	65
4	ove 60	108	24
	Total	410	139

The ageing profile of practitioners (Table 9.3) hints at the decline of the tradition. In Karnataka, the situation seems better than in Tamil Nadu, the reason for which is unknown. It can be predicted that after one more generation, many of these rich practices would become extinct. It is noteworthy that a unique tradition of management of spinal injuries (due to falling from trees) practiced in northern Kerala till the 1970s has already become extinct.

The total number of patients being consulted by each healer was calculated as per day/week/month. An average orthopaedic practitioner sees 250 to 300 patients in a month, an average of 10 patients a day. In Tamil Nadu, there are certain practitioners with patients numbering up to 200 per day.

Like in other specialties of local health traditions, for many vaidyas, this profession is not a livelihood activity. Some of them are agriculturists or have small family-run business, yet have continued their practice on the sidelines, as they consider it as a precious inheritance in their family. But unlike other branches of local health traditions, bone-setting is more formalised, and fee-taking is not taboo. In this study, healers who were consulting for cash are higher in count compared to others. It was found that among the people interviewed in Tamil Nadu, 199 healers (49 per cent) practise with consulting fee by cash, 10 healers (2.5 per cent) by kind, 25 healers (6 per cent) practise with whatever the patients give and 176 (42 per cent) did not disclose method of payment. In Karnataka too, majority of healers were consulting for cash.

Though this can be a lucrative profession, most vaidyas have maintained relatively low fees, which may be one of the reasons for large number of people still accessing them widely. For example, the average cost for treatment of a Colle's fracture per visit[1] is Rs 250-300, which includes bandaging and oil for external application. A story on the famous Puttur bone-setters goes that the clinic offers free service, and all that a patient needs is a few eggs and some white cloth, and a token contribution of one rupee. The healers here claim that most of their patients are labourers at construction sites, maid servants, poor children, and only a few were from the middle class (Nandakumar and Ghosh 2000).

78 out of 303 healers in Tamil Nadu who responded to this question, and 12 out of 139 in Karnataka, said they could read x-rays. Some of the healers refer complicated cases to orthopaedic surgeons or Ayurvedic or Siddha doctors-a demonstration of their potential utility in a contemporary public health context. It is plausible that with appropriate capacity enhancement, these practitioners could play a positive role in diagnosing complicated cases, and appropriate referral networks could be developed with formalised systems of medicine.

Safety and Efficacy

There are certain studies, largely from African countries like Nigeria, Ethiopia, Ghana and Sudan, indicating complications arising from traditional orthopaedic practitioners' practices (Burford et al. 2007). These studies highlight the complications arising out of wrong, tight methods of application of splints and bandage for fractures, leading to gangrene and, in some cases, requiring amputation. Often, there are also reported cases of mismanagement of dislocations and wrong techniques of massage etc leading to similar complications and conditions such as myositis ossificans (a type of calcification in the muscle tissue), and infections like tetanus, femoral artery aneurism, traumatic osteomyelitis, malunion and non-union.

In this study, we carried out a documentation of selected fracture and dislocations managed by healers to assess the safety and efficacy of the treatment. Selected centres were visited with

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[1] Each treatment requires two to three visits.

a mobile x-ray unit, and minimum of five patients of fracture or dislocation were recorded before and after the treatment using x-rays. A follow-up of these patients was also done after a period of seven weeks. During this process, unique techniques in diagnosis, treatment or medicine preparation, and reasons why people seek treatment from the practitioner were also documented. Selection criteria for healers[2] and patients[3] for the clinical documentation were set as per a research protocol. Informed consent of healers as well as patients was obtained prior to documentation. The data were analysed, and management practices evaluated, in consultation with expert comments from modern orthopaedic surgeons as well as Ayurvedic experts. Table 9.4 gives a summary of the findings.

Table 9.4 *Clinical documentation of five traditional orthopaedic centres*

Sl. No.	Centres	No. of cases recorded	Proper management	Complications (minor and major)	Remarks
1	Centre 1	5	1	3	One to be followed up
2	Centre 2	4	1	3	–
3	Centre 3	4	1	2	One to be followed up
4	Centre 4	4	2	2	–
5	Centre 5	8	6	2	–

There were some minor and major complications in around 45 per cent of the cases studied. Subsequently, these complications were systematically studied and reasons for these were ascertained. Almost all the complications were related to mal-union, and could be prevented by restriction in movement,

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[2] Healer inclusion criteria were — healer who accepts to be part of a clinical documentation, experience of the healers — a minimum of 5 years or more, number of patients treated per day — minimum 10 patients, consent — oral and written, currently practising, communicative, x-ray unit of his own/ accessible in nearby place.

[3] Patients inclusion criteria were — all fresh cases of fracture and dislocation, willingness to do documentation — consent (oral).

Patients exclusion criteria were — dangerous or distorted cases, cases which needs intensive care (emergency care), complicated cases, medico-legal cases, patients below 10 years and above 60 years, diseases (due to which fracture healing gets delayed) and pathological problems.

a simple measure that could easily be imparted to healers through training. Serious complications such as gangrene or infections were not reported. These findings were, however, based on small samples, and there is a need for more rigorous studies to ascertain common complications and reasons.

Following the documentation in Tamil Nadu, in order to share the findings of the study and to formulate future course of action, we organised a meeting with the Christian Medical College (CMC), Vellore, orthopaedics and community health departments. Around 40 selected healers participated in the programme. The initial response of the healers to the event was not enthusiastic, as they suspected its objectives. The main suspicion was whether participating in the programme would have any legal implications on their practice since they are not licensed practitioners. During the two-day session, however, the level of participation improved, needs of orthopaedic practitioners were identified, and a collective strategy for strengthening the tradition was charted.

Various strengths and weaknesses of their practices were also identified. Some of the strengths identified were their skills in management of simple forearm fractures, functional casts, usage of oils, internal medicines for faster healing and strengthening of musculature in the fracture location, cost effectiveness, accessibility, and social support. Weaknesses were identified as the problem of severe pain during management, frequency of mal-union, immobility in certain patients after traditional management, infections, difficulty in managing complicated fractures, lack of uniform quality or standards of practices, lack of documentation, and lack of legal support for practice. It was also discussed that through regular training and orientation, many of the clinical complications could be minimised. Many participants expressed the need of a healers' network for identifying good and bad practices, self regulation and strengthening the tradition. Most participants were open to the idea of training and formation of referral networks. A training module is being developed on the basis of these findings.

Reflections on Traditional Orthopaedic Practitioners' Roles

Three important questions arose from our experience: How can the practitioners' services be recognised and integrated into the

public health programmes? What are the ways and means to prevent rapid erosion of this tradition, and thereby strengthen it? How can the quality of care in TROP be improved?

Recognition and integration

Traditional orthopaedic practitioners are ambiguous entities in the eyes of the state. There is a widespread neglect of these practitioners in formal programmes, and there are absolutely no statistics on the number of practitioners or their contribution to the health workforce. There is also no uniform regulation on local health practitioners across different states of India. In most instances the vaidyas are not registered practitioners, yet, at the same time, governments have not barred them from practice. This official neglect continues to be a major hurdle in integrating these practitioners and their services with the formal health care system in any way. At present, social legitimacy and community support are the only factors supporting this tradition.

Healers of middle and lower strata are looking for some kind of recognition or legitimacy for their practice. Even attendance certificates of seminars are displayed on the walls to show that they have been part of a network, or have some kind of recognition. Often, there is discussion regarding getting licences from the government. In contrast, well-established healers are not concerned about this as they are pre-occupied with their clinical practice and enjoy the public support they have. Still, there remains a question on how long can these practitioners continue without any formal medical education or regulatory process. There are attempts to integrate vaidyas as community health workers to dispense conventional messages and drugs for community health, due to their accessibility in some remote areas. However, vaidyas assert that they wouldn't like to be known as 'community health workers' and merely dispense conventional medicines and messages, but would rather continue to play the role of a vaidya, as their knowledge and skills are specialised and they are carriers of such a mature tradition. They, therefore, want to be viewed as gram vaidyas or village doctors.

Another way to legitimise the role of traditional systems is institutionalisation. Institutionalisation of traditional orthopae-dics in Europe and other developed countries has paved the way for osteopathy and chiropractic today. At the same time, this has destroyed many diverse native traditional orthopaedic practices.

Any kind of institutionalisation of TROP in India has similar challenges, the major challenge being incorporation of many of the experience-based and personalised aspects into an institutional setting. It is worth mentioning that diagnostic tools such as pulse diagnosis, urine diagnosis etc, which were integral part of Ayurvedic tradition, are hardly taught or being practised by the institutionally trained physicians today.

The most promising avenue for augmenting the public health roles of traditional orthopaedic practitioners probably lies in building their capacity, and encouraging them to diagnose and refer complicated cases to the formal health system. As noted, a number of practitioners have already demonstrated adeptness at diagnosing complications and are presently involved in referring complications to allopathic specialists. Nevertheless, integration of traditional orthopaedic practitioners into mainstream health systems remains a complex issue with positive and negative implications for the survival of the tradition, an issue that has no easy answers.

Preserving the tradition

With time, many valuable aspects of this tradition are eroding. Though there are healers who are ready to impart their knowledge, there are no takers. There were attempts to introduce youngsters to the tradition through apprenticeships by some NGOs. Two such programmes started in Madurai and Idukki a couple of years ago could not survive, as the fellowship offered was too low. It failed to match with the daily wage earning, which is around Rs 150 a day. Also, the prospective fellows, or students, could not be assured a regular income compared to the daily wage once they started practice. Questions were also raised about the social and legal recognition or status of such newcomers after completion of their training with a healer.

Documentation of practices per se is suggested as a solution for preserving the knowledge from erosion and misappropriation. In line with this, today many NGOs are involved in documentation of traditional medical practices. Important challenges emerge around the documentation of TROP practices. Specialised skills and wisdom of the healers are usually transmitted through oral and apprenticeship traditions, and are not easy to document. A knowledge system like bone-setting is

particularly oriented around skills and practices, and does not just rely on replicable commodities, preparations or texts. Furthermore, given the decline of an active tradition of practice the functional utility of documentation remains limited, unless accompanied by serious thought and strategising on the future prospects and roles of the practitioners.

In order to save and strengthen practices which are of contemporary relevance, it is essential to have a national research strategy for traditional orthopaedics. One of the priorities is documentation and research of various aspects of TROPs, such as extent of coverage, current status, health seeking behaviour, safety and efficacy of these practices, cost-benefit studies etc. There are few studies on health seeking behaviour in musculoskeletal disorders and patterns of usage of traditional care facilities. As mentioned earlier, one of the reasons why traditional orthopaedics survives, especially in resource-poor rural communities, is the low cost and accessibility. The increasing number of private hospitals and the rising cost of modern care even in semi-urban areas may be other reasons. Cost-benefit aspects of TROP are also a potentially important research area.

Under a national research strategy, identification of potential best practices for further research, and cross referral between modern orthopaedic practitioners and traditional practitioners also form important areas. There are many unique aspects — *marma* (vital points), functional casts, usage of oils, various massage techniques, exercises, internal medicines and certain food supplements being some of them — for hastening healing time, reduction of local swelling, strengthening local musculature, improving mobility and minimising complications. Many of these management approaches are systemic and holistic in nature and point to an epistemological difference in understanding of musculoskeletal system in traditional medicine. Each of these warrants detailed research. Here, one is reminded of the example of 'Puttur kattu', a special cuff-and-collar sling[4] which prevents wrist drop in forearm fractures. This is now adopted by a renowned orthopaedic hospital in Chennai founded by Dr Natarajan.

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[4] This consists of two slings, one tied at the wrist joint and the other tied at the angle of the thumb and the palm. These two slings are tied together above the wrist in order to prevent wrist drop.

Similarly, there are certain special preparations which are being mass marketed today. *Murivenna*, a potentiated oil formulation which is a household name, is one such preparation that has got commercialised from folk knowledge. Such integration would enhance popular appeal of these practices and confidence among traditional practitioners.

Reducing complications and improving quality of care

Another important area that warrants immediate attention is improving the quality of care by traditional practitioners and reducing complications. According to Onuminya (2006), in Nigeria, there was a significant reduction in complications in the bone-setters' management after systematic training programmes. One of the challenges in developing an appropriate training programme is to make it participatory and sensitive to the strengths and needs of bone-setters' practices. Here, one is reminded of the fact that earlier attempts in training traditional birth attendants have often acted only to promote conventional medical management and medicines to the detriment of many valuable aspects of local health traditions. There are many traditional orthopaedic centres providing excellent service as mentioned in the introduction of this chapter. There are also Ayurveda and Siddha centres. These centres can be made regional centres of expertise and be utilised for training programmes of young vaidyas in respective areas. These centres could also form regional research hubs in the area of TROP.

With respect to quality of care, another point noted is that due to lack of analgesics, the pain factor is very high in healer's management. Udosen et al. (2005), in their African study, mention that due to lack of analgesics, in many cases during reduction, the suffering of patients is high. According to our study, though most practitioners refrain from using any modern analgesics, there were some practitioners who mentioned that they used them as and when required. The use of analgesics in TROP is an aspect on which the practitioners may benefit from simple training initiatives.

In conclusion, there is no doubt that traditional orthopaedic practitioners are significant and popular providers of health services in rural areas. Lack of proper documentation of safety and efficacy, health seeking behaviour, lack of appropriate

training programmes and organisational support are some of the key challenges faced by TROP today. There is a need to critically appraise and recognise the contribution of traditional practitioners to public health in areas where health care is not accessible. A national strategy for appropriate networking of practitioners, recognition, regulatory mechanisms, suitably designed training programmes to address local needs, identification of unique practices and their research are all needs of the hour. It is laudable that the 11th Five Year Plan of the Goverment of India (2007-2012) has introduced schemes for strengthening local health traditions, including traditional orthopaedic practices. These schemes are expected to support pilot programmes such as integration of traditional orthopaedic practices into public health care system, training of caregivers, carrying out research on selected unique aspects, and promoting centres of excellence of TROP. It is too early to tell whether these government efforts will succeed, but they are certainly steps in the right direction.

Acknowledgements

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Chapter 10

The Critical Role of Family Care Providers in HIV/AIDS

Stories from Rural Maharashtra

Shilpa Karvande, Vidula Purohit, Karina Kielmann, Rajendra Kale and Sheela Rangan

*P*andurang[1] *and Radhabai Sonavne live in a small village with Pandurang's old mother and two children. Pandurang worked in a city for 2-3 years, earned some money and came back to his village. His four brothers have migrated to the nearby city and live their lives independently. The Sonavne family had a small piece of land. Pandurang, after his return to the village, started looking after farming and was able to feed his family. He would frequently fall sick with loose motions and weakness, and seek treatment from a private doctor. He had good relations with all his brothers and also with his wife's family who lived in a nearby village. His brother helped him seek treatment whenever he would fall ill. This went on for almost two years. Pandurang knew that he was HIV positive but had disclosed his status neither to his wife nor his mother.*

A few months ago, Pandurang fell sick again. His condition became serious and he decided to take help from his father-in-law. But due to the death of a distant family member, his father-in-law could not immediately help him consult a specialist doctor in the city and took him to a local private doctor. His health worsened and after a few days, his father-in-law and brother got him admitted to a private hospital in the city nearby. Various investigations were carried out and these revealed his HIV seropositive status to his father-in-law. His father-in-law could not believe it. Some other family members and relatives who

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[1] Names of the persons in all the stories have been changed to protect confidentiality.

came to know about it were shocked too. All of them cried in the hospital, but his father-in-law decided that while he would help Pandurang, he would not allow his daughter to stay with him. He spoke to the doctor, spent money for him, arranged medicines for him and stayed with him for four days. Then he had to return to his village to look after his farms. Pandurang decided to take a discharge from the hospital and, without informing anybody, returned home.

Pandurang did not like his father-in-law's decision of not allowing his wife to live with him. He had badly wanted his wife to be with him during his hospitalisation. But his wife Radhabai had no say in this matter. She, along with their children, went to her father's house. Pandurang's old mother was not aware of what had happened to her son. Pandurang was now left alone with her. As the daughter-in-law no longer stayed with her, the old woman had to manage all the household chores, cooking different food items as per Pandurang's demands. He would not be happy with the routine food she cooked and would keep complaining about it. She would walk distances to collect firewood and fetch water. Her eyesight and hearing were poor. She could not understand what exactly had happened to her son. He told her that he had AIDS and that he was going to die. The old lady would cry everyday with this thought.

After a few months, Pandurang fell seriously ill and his brother took him to the district government hospital. Pandurang wanted his father-in-law to help him again. But his father-in-law was angry with him as he had come to know through another relative that Pandurang, despite knowing about his illness since long ago, had continued to have sexual relations with Radhabai and had not disclosed his status to them for more than a year. He went to visit Pandurang only because his brothers had sent a vehicle to pick him up from his village and take him to the hospital.

Pandurang had now been diagnosed with TB. The doctor there informed him about taking TB medicines from a primary health centre near his village. His brothers struggled to look after him while he was in the hospital. Since their wives were employed as maids, they could not get him food from their houses. Pandurang kept complaining about the 'bad and tasteless' food in the hospital and once again, against the permission of the doctor, returned home. His father-in-law did not like this.

His mother was worried about his health and discussed this matter with other relatives. All of them went to his father-in-law's house to convince him to send his daughter back. He admitted that though he did not like to keep his married daughter in his house, he was worried about sending her to her husband. Finally, he decided to send her back. He went to Pandurang's house and advised him about some dos and don'ts, like keeping his bedding and utensils separate and not going close to his wife or children. He told his son-in-law that he should treat his wife as his sister, not as a wife. Pandurang promised to do so and his wife came to live with him along with their younger son. Their daughter continued to live at her grandfather's house. Pandurang's father-in-law bought condoms and gave them to his daughter. He felt ashamed to do so, but was helpless. He said, 'I don't know whether I am sending my daughter there to die! After all he is a "man" and I don't know how far and how much he would keep his promise.' He was worried about Pandurang's financial status as well, because he was the only working hand in the family. The father-in-law supported them as much as he could. This year, Pandurang's brother from the city came to help him with the cultivation. He had to pay labourers to get the work done in the farm, so that the family did not lose a year's crop.

Pandurang's health improved after he completed the course of TB medicines. Later, he was enrolled in the government's antiretroviral therapy (ART) programme and started ART. His wife tested herself for HIV once and was told to repeat the test after three months. She knows she should, but has not gone for repeat testing. Both her children are HIV negative.

This is just one of the stories from our study on families affected by HIV/AIDS in rural Maharashtra. It represents the lives of several families who live with and take care of their loved ones living with HIV/AIDS. In typical rural Indian families, like that of Radhabai and Pandurang, extended family structure, kinship orientation, gender dynamics and local cultural context determine how a family can, or will, perform the role of care giving. The story raises many questions that are not answered and addressed adequately in policies and programmes — how well-equipped are the relatives and

members of the immediate social network to provide care for the individual living with HIV? Who provides them information or advice regarding HIV care? What can be done to help them access antiretroviral drugs for the people who are under their care? Is there a platform to share their feelings and stresses? In what ways, if any, are formal health providers lending support to the informal care providers in these households?

It is estimated that 90 per cent of illness care is provided within the home (Ogden et al. 2006). In countries like India, where the family remains a core and a fundamental social unit, family members represent the largest group of care providers for illnesses. Informal care provision by family members in households affected by HIV/AIDS has been studied in relation to the impact of illness on the structure of family (Seeley 1993), stresses of care provision (UNAIDS 2000), and recognition of care efforts (Ogden et al. 2006).

Studies in India have focused on needs of women caregivers in rural context (Pallikadavath 2005), and experiences and perceptions of caregivers around informal support (Cruz 2002). Studies have also mentioned that care providers experience extreme stress, and hence stress management for care providers has to be on a priority list of care agenda (UNAIDS 2000). The organised volunteers acting as caregivers at least have a possibility of sharing their feelings with other members, time off for themselves, and support from formal sectors (UNAIDS 2000), unlike care providers in the family. Further, where physical access to health services itself is an issue, like in rural or remote areas, care providers have additional challenges to overcome while looking after an HIV positive person.

Most of care providers in the family are women (Ogden et al. 2006; UNAIDS 2000; Taylor; Seeley & Kajura 1996), and hence the issue also needs to be looked through a gender lens. A study carried out with HIV-infected women acting as care providers for their husbands and/or children (Joseph and Bhatti 2004) showed that their HIV positive status makes them a unique group with unique problems and needs. Especially where they have a secondary status in the community, being female may exacerbate the burden of care of a person living with HIV. Women in India, similar to the situation in Uganda (UNICEF 1989), always have the burden of childcare, household chores,

farm labour and other caring activities at home. Studies have been conducted in India (Joseph; Bhatti 2004) and rural Uganda (Taylor; Seeley & Kajura 1996) to study problems faced by women care providers, and their coping mechanisms while handling a sick person at home. As pointed out in a study carried out in rural Maharashtra (Pallikadavath 2005), there are limited resources available for HIV-infected women to take care of their children, sick husband and themselves.

In summary, the role of family care providers in HIV care has received some recognition from researchers worldwide, yet little has been done at a practical level to formally recognise the efforts of family care providers and to support families bear the burden of performing this role. Even as the third phase of the National AIDS Control Programme has identified the need to have community and family-based response in the care and support agenda through the community care centres (NACP III 2008), clear strategies for implementation are limited and need elaboration. With this background, we decided to explore the experiences of families affected by HIV/AIDS in rural areas of Maharashtra, with a particular focus on family members acting as caregivers. The objectives were: (a) to study the profile and needs of care providers in the families of people living with HIV (PLHIV) and (b) to understand the roles, relationships and dynamics among these family members. The study documented the experiences of 22 PLHIV and 31 of their informal care providers over a period of seven months in the year 2007.

Methodology

The study site, Maval tehsil, is located next to Pune city. It is one of the fastest developing tehsils of the district, with many upcoming industries, education institutes, plant nurseries and floriculture. However, the site remains typically 'rural', with a kinship-oriented agrarian community dominated by the Maratha caste. Most of the families are either joint or extended. Most of the younger community members migrate to Pune or Mumbai in search of jobs, live there for a few years and return to their villages. There are two main towns where most of the private medical practitioners, private multi-specialty hospitals, markets and shops are clustered. The tehsil has six primary

health centres (PHC) and two rural hospitals (RH). There are three government-run Integrated Counselling and Testing Centres for HIV/AIDS (ICTC) in the tehsil.

In order to undertake this study, the researchers developed rapport with the staff of three PHCs, discussed the study objectives with them and sought their suggestions about how to approach PLHIV in the community without breaching confidentiality. The PHC staff were willing to support the study and acted as first-level consent seekers for the respondents. They contacted the respondents, explained the study to them, and sought verbal consent. Only those who gave their consent at this level were recruited in the study. Privacy and confidentiality were two major issues throughout the study. The researchers took utmost caution and also trained the participating PHC health workers about not discussing any of the cases in public and not revealing any names even among themselves. The place and time of the interview were pre-arranged by the PHC workers in consultation with the respondent. The interviews were conducted in the household or on the farm, or at the PHC, as per the convenience of the respondent. It was a huge challenge for us to interview HIV-infected individuals and their family members about their life experiences in their 'real-life setting'.

The study participants were selected purposively, drawn from the community with the help of the involved PHC workers. In total, 25 PLHIVs were identified from three PHC areas, of which 22 gave written consent to participate and were interviewed. Of these PLHIV, 11 were men and an equal number women. The selection included three concordant couples. Thirty-one family care providers of these 22 PLHIV were also interviewed.

Family Care Providers

Family care providers were identified as individuals who were closely involved in the care of the PLHIV, either on the basis of our observations or on the basis of the respective PLHIV's account. Some of them resided in the same household as that of the PLHIV. As the study setting was rural, most of the cases and their care providers had an agricultural background and had studied up to secondary school or less. All the respondents were above the age of 18 years. Immediate family members, as well as other relatives, were involved in providing care to the

PLHIV. Table 10.1 shows the relationship of these care providers with the cases.

Table 10.1 *PLHIV and their family care providers who participated in the study*

PLHIV[2]	
Men	11
Women	11
Total	22
FAMILY CARE PROVIDERS	
Of male PLHIV:	
Spouse	10
Parent(s)	1
Brother	2
In-laws	3
Brother-in-law	2
Son	2
Total	20
Of female PLHIV:	
Spouse	5
Parent(s)	2
Brother	2
In-laws	0
Brother-in-law	1
Sister-in-law	1
Total	11

Dimensions of Family Care

Care providers were engaged in providing 'direct' care for the sick, which involved nursing the patient, maintaining cleanliness and hygiene at home, cooking, doing household chores, looking after children etc, and 'indirect' care, which included giving financial assistance, arranging transport or accompanying the patient during his/her illness episodes or hospitalisation, counselling and psychological support. The 25 care providers who shared the same household as that of the PLHIV were mostly engaged in providing direct care to him/her. Those who provided indirect care were either brothers living in other cities and villages, or the wife's mother, father, sister or sister-in-law. For many men, in-laws were key care providers and supported them

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[2] This selection included three concordant couples (i.e. both husband and wife were HIV positive).

either out of a sense of duty towards the son-in-law (implicitly reflecting their concern for 'wifehood' as opposed to 'widowhood'[3] for their daughter) or out of genuine concern towards him. In some cases, indirect care providers also supported the direct care providers, for example, in one case, the wife provided care for her husband, and her mother continued supporting her financially and giving her psychological support. In another case, a man's brother offered help in farming, thus helping his direct care providers and the entire household. The diagram below (Figure 10.1) is an attempt to illustrate some examples of what these dimensions of care mean:

Direct care		PLHIV		Indirect care
Son	⟶	Father	⟵	Brother
	Nursing of terminally ill father		Legal/ property matters	
Wife	⟶	Husband	⟵	Wife's father
	Nursing, household chores		Shelter, financial help	
Wife	⟶	Husband	⟵	Wife's Brother
	Arranging NGO support		Psychological support	
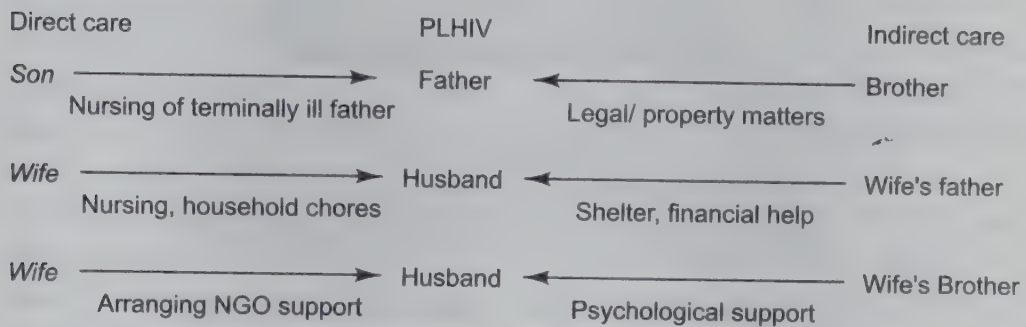
Figure 10.1 *Dimensions of family care*

Looking at the scope of care provided in the households affected by HIV, we found that the tasks and the perceived 'burden' of care differed according to the patient's stage of illness, but were also linked to issues of family background and dynamics.

Pyramid of Health Status of PLHIV

Generally, levels of care for the PLHIV differ according to stage of illness (Figure 10.2). The bottom layer consists of asymptomatic PLHIV, the middle layer represents PLHIV with recurrent opportunistic infections, and the topmost layer relates to severely ill PLHIV. There are some specific needs of family care providers of PLHIV representing these three layers, and obviously, the ones in the topmost layer need additional support and intervention. In the following section, we present some

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[3] In rural Indian society, widowhood implies loss of status and respect for a woman.

stories to illustrate differential needs of the care providers according to the different health status of PLHIV.
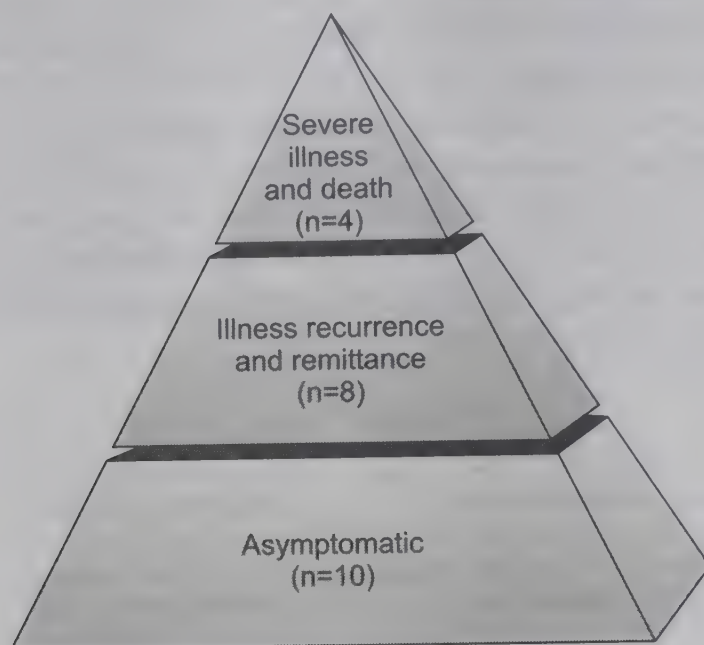
Figure 10.2 *PLHIVs' health status 'pyramid'*

Care Providers of an Asymptomatic PLHIV: Ramesh

Ramesh and Vanita have a 7-month-old daughter. Vanita was diagnosed with HIV during her pregnancy and both of them were 'shocked', and 'collapsed' on hearing the diagnosis - 'We both would not eat anything, not talk to each other for days'. Ramesh and his wife were counselled about the importance of institutionalised delivery, and accordingly, Vanita opted to have her delivery at a tertiary hospital. Ramesh took care of her during her pregnancy and also during hospitalisation at the time of her delivery as they did not want other relatives to know about her illness.

He has been struggling with his finances but does not want to take help from any of his relatives since he does not want anyone to know about Vanita's illness. Ramesh is very caring towards Vanita and has agreed to abstain from sex. He says, 'I have had enough tensions and stress in my life, now I don't even want to know my HIV status. Let it be anything.' Both he and Vanita appreciate the government health centre staff for providing them with knowledge, information and support

whenever they have been in need. Vanita was never really sick; in fact, it was hard for her and her husband to believe that she was HIV-positive.

Ramesh may well represent a unique case in terms of his care and support towards his wife, and we are left wondering if he will have a platform to share his feelings and stresses. The couple appear to have been fortunate in terms of the support they receive from the formal public health sector staff, which raises the question as to whether every PLHIV and their caregivers can claim the same?

As is mentioned earlier, 10 of the PLHIV in the study were asymptomatic, and in three cases, they had minor illnesses. Family care providers experienced specific issues or needs at these initial stages of illness. Intimate relationships between married partners were at stake in most of the cases, as was the case with Ramesh and Vanita. Wives who acted as care providers spoke about the stress and pressures of having safe sex. Many claimed that they were living 'like brother and sister' since hearing about the diagnosis. Some of the wives were not sure about safe sex practices. As they were afraid of becoming infected, they sometimes chose to break the marital relationship and live with their parents for some time. However, due to a sense of duty and concern about their children's future, some decided later to return to their husbands. Marital and sexual lives remain under strain.

> 'He says, "come close" (but) there is always a fear in my mind that I will get the disease then…But then he starts throwing tantrums.' — HIV negative wife who returned to her husband after some time with natal family
>
> 'We have now decided to concentrate only on our daughter's life. We look at her and spend our time and forget about everything else. We don't let any other thoughts come to our mind.' — HIV negative husband of a 32-year-old infected woman having one daughter

Some couples did mention the use of condoms, as well as abstinence. One couple spoke about how they satisfied themselves without having actual penetration. They were constantly worried about how strictly and how far they would be able to follow it.

Vanita and Ramesh both knew about the importance of HIV testing for the spouse, repeated testing for HIV, having hospitalised delivery for an HIV-infected pregnant woman, and hence Vanita had her delivery at a district-level tertiary hospital. She could save her daughter from getting infected. However, there were other couples who lacked knowledge about partner testing, or did not give it due importance. In contrast to Ramesh and Vanita, who seem well-informed about the diagnosis and course of illness, many PLHIV and their families were poorly informed and suffered unnecessary stress and fears, as illustrated in the following quotations:

> '....*But I am worried, he is a "man" if he does not listen tomorrow then it will spoil my daughter's life. Can you suggest something for that?*' — Father of a young married woman with an HIV-infected husband
>
> '*We are using condoms at the time of sexual contact but what are the chances that germs can be transmitted through breath or saliva, especially while kissing?*' — HIV negative wife, care provider for her husband.

An old mother living with her young HIV-infected son did not know about his illness and kept crying as he had told her: 'I am anyway not going to live for long.'

These examples demonstrate that disclosure of HIV status to family members should include imparting knowledge about HIV, its causes, routes of transmission and prevention, and treatment available, if we are to expect family members to be supportive towards PLHIV. Lack of knowledge about the need for testing and testing facilities is a significant area of concern. We found that hardly any of the family care providers had knowledge about the HIV testing facility available in the public sector in the study area, and invariably all of them asked the researchers for this information. Moreover, knowledge about the need for partner testing was rare, especially among wives or widows.

The disclosure of diagnosis of HIV disturbed some PLHIV, as well as their family care providers. As with Ramesh and Vanita, many couples had difficulties in accepting the diagnosis. However, frequent and ongoing interactions with the local health staff helped these families understand the illness and deal with its consequences in a positive way. The role of the

counsellor and other local public health care providers was crucial to help families deal with the shock of diagnosis.

Knowledge about prevention of opportunistic infections and maintaining health of the PLHIV is yet another need. It was evident that family care providers did not get any opportunity to avail knowledge about diet, exercise and opportunistic infections. As we move on to the next layer, the needs of families become more specific.

Care Providers of a PLHIV with Recurrent Opportunistic Infections: Bhamabai and Vitthal

Bhamabai and Vitthal are an old couple who live in a small village in a hilly region. Their 30-year-old daughter Nanda is living with them for the last two years, following the death of her husband. Her six-year-old son lives with her aged in-laws. Nanda was tested for HIV after her husband's death, and found to be positive. She became weak and continuously suffered from one or the other illness. Since her in-laws were very old, Bhamabai decided to bring Nanda back with her to give her better care. Bhamabai and Vitthal cultivate rice on a small piece of land and also work as farm labourers. Every time Nanda falls sick (which is quite often), Bhamabai has to forgo her wages for the day and take her to a local private doctor who charges Rs 100 for treatment. Due to her frequent illness episodes, Nanda is not able to contribute to household chores. Most of the time, her mother has to feed her, help her take a bath, and take her to the toilet in the open field outside the house. Bhamabai and Vitthal have been told that Nanda needs to receive ART, but they are not yet convinced about its effectiveness since they do not know much about it. They have several concerns about taking her to the city ART centre. They already have a hand-to-mouth existence and are not sure how they will cope with the added expenses of taking Nanda to the city for treatment. Bhamabai is also distressed that her only grandchild has to live without his mother and look after his paternal grandparents while he studies. The family has to deal with Nanda's sufferings with recurrent opportunistic infections, and is not aware about accessing affordable services for treating Nanda's infections. How Vitthal and Bhamabai can be helped to treat Nanda and live their normal family life, remains a question.

At this stage, the PLHIV are symptomatic and consequently, his/her care providers have additional issues related to taking physical care during illness episodes. There were eight PLHIV who started suffering with one or the other opportunistic infections. In case of Nanda, Bhamabai and Vitthal do not know that the recurrent infections their daughter has are related to her HIV status. They are not aware about what should be done to prevent recurrent infections, nor about what services to avail of when she suffers from any of these infections. Thus, not only do they need the knowledge but also the skills of management of opportunistic infections at the household level.

Similar to Nanda's parents, many families wander from pillar to post in search of help and bear additional financial burden due to the expenses of treatment. In addition, inaccessible public services and limited knowledge about services available in public sector force families to seek help from locally available health care providers. As in the case of Bhamabai's family, they have frequent contacts with a local private medical practitioner who is their 'family doctor', and have full faith in his words. This doctor has told them that Nanda's illness has no cure and hence no medicines can help her. When family care providers have limited knowledge about opportunistic infections or ARVs, this sort of advice or counselling becomes a barrier in availing appropriate services from the public sector.

In other instances, however, PLHIV and their care providers had close contacts with the local public health providers. They were given information about treatment of opportunistic infections, and counselled for positive living. They appreciated the support extended by the health staff.

Families have different strategies to respond towards the illness, especially when symptoms and suffering are visible. Some families had accepted the course of illness in their family member, and did not appear to suffer an undue impact on their lives. Other families employed coping and survival skills to face the challenges. The mother of a PLHIV told us how the entire family preferred to hide the illness from their relatives and other community members and referred to it as 'jaundice'. Fear of social stigma worried these families, and as Bhamabai says, 'Village women keep coming and visiting her whenever she falls sick. They keep asking about her illness, but I give them some

vague answers.' She further said, 'Because she keeps falling sick, we never know when she is going to be fine or when she will die, so we don't feel like celebrating any festivals in the family.' Recurrent infections in the PLHIV also raise the issue of the need for emotional support for the family care providers.

For most of the families with an agricultural background, paying for the direct costs of treatment of recurrent opportunistic infections was quite challenging. Three women mentioned selling their jewellery in order to pay the hospital bills of their husbands. In case of one male respondent living with HIV, his wife's father and brother were major sources of financial support. As in Bhamabai and Vitthal's case, spending 100 rupees every time for their daughter's visits to the local private doctor was difficult. Often, they had to postpone the visit till they could arrange money and an escort for her. Invariably, it was the mother who sacrificed her daily wages.

There were instances where care providers had to compromise on other expenditures at home, for example, expenses on children's education and clothes. Wives expressed concern about their inability to save money for their children's education and marriage. Families suffered as their farming and other family businesses were affected due to the recurrent illness episodes of the PLHIV and family members getting more engaged in taking care of him during this period. One PLHIV's brother, who lived in the city, returned to his hometown to assist his sick brother in rice cultivation. The brother had to compromise with regard to his work back home, and his family had to adjust with his absence for a few months. Old parents of male as well as female PLHIV were compelled to work and earn in order to run the family and take care of their children. Sometimes, wives asked their fathers for financial help.

At this level of illness, family care providers not only have to gain the knowledge about the illness and the available health services, but also have to learn the skills of giving nursing care to the PLHIV having recurrent opportunistic infections.

Care Provider of a Severely or Terminally Ill PLHIV: Drupada

Drupada is a widow with three children. She lives with her in-laws. Her husband was diagnosed with HIV two years ago. He

consulted a private doctor in Mumbai and was advised to take antiretroviral drugs (ARV) for six months. He did as he was advised and discontinued the treatment after six months. Later, he was diagnosed with TB and Drupada forced him to live separately in the next house due to fear of infection. He begged her to allow him to live with his family. She took him to a nearby PHC. The medical officer wrote a prescription note saying 'Urgently needed ARV', and gave it to her and asked her to take him to the tertiary hospital as his health had worsened. Drupada, who had never stepped out of her house, took him to the tertiary hospital. She narrates her experience, 'It was my first time to go to a city. I felt lost in the huge hospital campus. My husband was very weak and unable to walk. I could not locate the (ART) centre.' So, she took him back home. The next week, her husband died.

Drupada had always trusted her husband and still does not understand how he got the infection. When her husband was alive, Drupada had never stepped out of her house and never knew about her husband's investments or financial transactions. There is also a bank account in her name, an account she does not have any information about. She is scared to go out and ask the village leaders to help her. Her children are very young; her husband's brother's son sometimes helps her and has given her some money. Drupada's sister and her husband helped in Drupada's husband's treatment with the private doctor. Her mother, a widow who will soon retire from her government job, is planning to come and live with Drupada to take care of her family. Her old parents-in-laws are dependent on her, and she singlehandedly manages her family expenses by working hard in the farm. She knows about HIV testing facilities in government hospitals but prefers saving money to go to a private doctor.

Drupada could not seek help from anyone to avail ART for her husband in time. Moreover, her husband's death came as a shock for her. Their story raises questions such as whether Drupada could have been prepared for her husband's death, and whether she can be supported to have a healthy life for her and her children after her husband's death.

The topmost layer of the care pyramid translates into several challenges for the family caregivers. There were four PLHIV in the study who were terminally ill and died during the study period. For providing care to the severely or terminally ill PLHIV,

who have gone through various stages of the illness, families have additional needs in terms of knowledge, access, logistics, support from health sector and counselling for a range of subjects, in addition to all the issues discussed for the first two stages.

Drupada's story illustrates a major need for helping the family access ARVs in case of a severely ill PLHIV. Drupada, even today, blames the local medical practitioner for not telling them in detail about the urgency of getting on to ARVs, and about the available ART services.

The case of another widow who was taking care of herself was similar. She was totally unaware about the availability of ARVs in the public sector. These families need counselling about what CD4 means, about prerequisites for enrolling for ART, and how best to support adherence for the person on ART. Most families feared approaching the district-level public hospital and, hence, delayed the decision to take the patient for ART. Some families were not convinced about the effectiveness of ARVs and preferred taking medication from local private medical practitioners for various recurrent opportunistic infections. The role of the private practitioner was seen to be crucial in increasing awareness about ART among families.

In an exceptional case of severe negligence, the wife and two young sons of a severely ill PLHIV would lock him in a room, fearing infection. They did not take care of his food, hygiene and medications, and he died within a month of his family members starting to ignore him. They were not aware of the existence of treatment for HIV and AIDS. His wife and sons later said, 'We should have known about all these things... testing and medicine before. We were very scared of him.' This shocking case illustrates the level of neglect and abuse that can occur due to fear and misconceptions.

The most challenging aspect of caring for severely ill patients in the rural context was in making logistic arrangements. Raising money, seeking assistance from distant relatives and arranging a vehicle for escorting the patient to the hospital posed difficulties and delays, as illustrated in Drupada's case. In a joint family, men had a key role in providing this indirect, but very important, timely help for the patients. However, due to lack of knowledge regarding where to take the patient and how much money is needed for his treatment, these efforts did not

always result in timely and appropriate treatment. Very often, the wife's parents (as in the case of Drupada) and brother had a key role in making all the logistic arrangements. In another case of two men with HIV infection, their father-in-law had sold their land to bear the recurrent hospitalisation costs for them. Another old man explained, 'I have exhausted my savings during his (son-in-law's) hospitalisation, now if he wants to come and stay with me along with his wife and children, I will not be able to support them.' The young son-in-law, who was seriously ill, wanted to take shelter in his father-in-law's house.

It was seen that care provision involved multitasking and most of the times, the family members were torn between their caring roles and other responsibilities related to their roles and relationships within the family. Drupada said, 'In his last days... he was bedridden for 8-10 days and would keep calling me, but my children would also want me, and I did not know who I should attend to.' She mostly avoided attending to her husband, not realising the severity of his illness in his last days.

Drupada preferred not to disclose the name of her late husband's illness to other relatives and kin in the village out of fear of stigma. Her husband was not terminally ill for a very long period, and probably due to this, she did not have to face questions from the community around his ill-health. However, in the case of the three other PLHIVs who died during the course of the study, the stigma experienced by family members definitely called for active support by various sectors.

> 'My brother got two proposals for his marriage. One of them came to know about our father's illness and refused him. We have decided, we will not hide it from anyone now. Let them decide what they want.' — Young man whose father died of AIDS
>
> 'My parents faced discrimination from the community and could not digest that shock. Now they are no more. I want to progress in my life and do something for my house and I will show the rest of the world that I can do something.' — Young man orphaned and living with relatives

In both these cases, the HIV positive persons were bedridden for a long period, and the entire family and community came to

know about their illness. As was the case with families of recurrent opportunistic infections, these families could not use any effective strategy to hide the illness from the community. Time had to pass until they could overcome the discriminatory behaviour from relatives and other community members. None of these care providers knew whom to approach to learn more about the illness and empower themselves to face the social reactions.

Families need much more support from government and charitable health care facilities during this phase. Family care providers tended to interact with formal health staff only at times when PLHIV were hospitalised. The local level health staff themselves expressed the need to have more knowledge about various issues related to HIV care, especially about ART, so that they could be a better source of knowledge for the community. Once PLHIV enrolled in the ART programme at the district level, there tended to be little interaction among them, their families and the local health care providers. Families seldom knew how to take care of a patient on ART. Most of the families in this 'layer' of the pyramid had seen significant ups and downs in the health of the PLHIV, and were often physically and financially exhausted.

Apart from the local public health facilities, a local non-governmental organisation (NGO) was seen to be an effective source of support for some of the families. Some women had contacts with the local branch of the Network for Positive People through this NGO and were aware about the available HIV services. This NGO provided health care by providing tonics and non-prescription medicines, counselling for care and support, providing an escort to reach the ART centre, and networking with other NGOs for various other services. Families of affected couples who had contacts with this NGO were more aware about HIV, and the couples themselves were more empowered and educated about the various issues which, in turn, reduced the care burden for families. However, family members had only sporadic interactions with the NGO.

Conclusion

Family care providers currently face several kinds of direct and indirect responsibilities while providing care to PLHIV. These include the physical aspects of care provision and struggling

with illness prevention, the financial aspects of managing the illness, the emotional burden of coping with the illness and helping the PLHIV cope, as well as facing the social repercussions of the disease.

There are some positive factors that support PLHIV and their care providers in rural communities, such as presence of an NGO or Positive People's Network, initiatives taken by local public health functionaries at individual level to interact with the PLHIV and their family members. However, they seem to be an exception rather than a norm. Also, there are worrisome aspects with regard to the capacity of the health providers in the public and private sectors to provide appropriate knowledge and guidance needed by families affected by HIV.

In addition to these general needs and issues that are applicable to all the family care providers of PLHIV, the study shows that different stages of illness require attention to specific issues in care provision. Family members of non-symptomatic PLHIV need knowledge about HIV, emotional help to understand and cope with the diagnosis of HIV, preventive measures, including safe sex practices, and measures to prevent opportunistic infections, so that they can support the PLHIV in living a healthy life. Those providing care for PLHIV with recurrent opportunistic infections need to know ways to manage and prevent opportunistic infections, and coping strategies to deal with the emotional burden of care giving. Family care providers supporting severely ill PLHIV need to be aware about ARV treatment, and be equipped to handle severely ill PLHIV at home; for example, having the skills to take physical care of the bedridden patients and receiving support in terms of preparing the household for the eventuality of death of the PLHIV.

It is commendable that the third phase of the National AIDS Control Programme (NACP-III) has given due importance to the role of the community and the family, realising the need for decentralised care for HIV. However, there should be due consideration given to the needs and capacity of the family as care providers. While implementing a family-centred care and support programme, the multilayered nature of care that we have documented should be acknowledged. Mechanisms for regular and scheduled interactions between family care

providers and the formal health sector will be useful in implementing such a support programme. A structured and strategic approach can strengthen the family in terms of being able to bear the mental and physical burden of care, and equip them to be more effective participants in the care continuum for PLHIV. Various countries are scaling up their national HIV/ AIDS programmes in response to reaching the goal of having 'Universal Access to HIV/AIDS prevention, treatment and care by 2010'. However, the care programmes, especially in a resource poor settings as that of India, need to gear up to create strong and durable human capacity at each point on the care continuum. Even though family care providers are being increasingly recognised as key players in research circles, further practical steps need to be taken to support them in shouldering the burden of providing care for their loved ones.

Acknowledgements

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PART IV ADAPTING, TRANSFORMING: PERSONAL EXPERIENCE IN PROFESSIONAL SPACES

Chapter 11

Sexual Harassment of Women Health Workers

Individual and Organisational Responses
in Kolkata Hospitals

Paramita Chaudhuri

S exual harassment occurs virtually in all workplaces to
varying degrees, though it is often unacknowledged. This
chapter builds on qualitative research about health workers'
and administrators' experiences and views on sexual
harassment in Kolkata hospitals (Chaudhuri 2006). While the
nature of this sexual harassment has been detailed elsewhere
(Chaudhuri 2007), this chapter focuses on the responses of
women health workers, their colleagues and superiors to the
problem. The chapter starts with an overview of the regulatory
and occupational context of the study. It then draws on study
findings to briefly outline the nature of sexual harassment in
hospitals, before discussing the nature of individual views about
the problem.

This research is based on an exploratory study and the author's
subsequent experience of working with various hospitals in
Kolkata. The research was conducted in four large hospitals in
2005, two being government-run and the other two being private.
The two government hospitals were selected on the basis of their
different locations and the wide range of medical services
provided. Permission was given by the Department of Health,
Government of West Bengal, for conducting the study in the
government sector. With private hospitals, letters requesting
permission, along with recommendations from the Department
of Health, were sent to almost all the large hospitals in the city.
Authorities in most private hospitals refused to participate in
the study. Research was finally conducted in the two private
hospitals that gave consent.

A total of 135 in-depth interviews with women employees from two government hospitals (38 and 34, respectively) and two private hospitals (29 and 34, respectively) were conducted over a period of 11 months. In order to obtain perspectives of a range of personnel, doctors, nurses, health care attendants (unqualified nurses), non-medical staff (including stewards, sweepers, peons and ward boys) and administrative staff (including public relations officers) were interviewed. In all the hospitals, authorities gave access to the respective heads like nursing superintendents and the heads of departments, who then provided access to their staff. In addition, a total of 40 key informant interviews were conducted with hospital, union and association heads to better understand the redress mechanism, and the frequency with which it has been used.

Regulatory Context

In India, the issue of sexual harassment came into mainstream public discourse when, in 1997, the Supreme Court of India, for the first time, recognised sexual harassment at workplace as a violation of human rights. The landmark judgement outlined a set of guidelines that instructed authorities and employers[1] to institute rules of conduct as preventive measures to stop sexual harassment, and to set up complaints committees to redress instances of sexual harassment within organisations. In order to make these committees representative of women's concerns, the guidelines mandated that they be headed by women, have at least half its members as women, and should include a third party representative from a non-governmental organisation or any other individual conversant with the issue of sexual harassment.

The implementation of these guidelines has not been as effective as hoped. In some instances, employers are unaware of their obligations to abide by the guidelines. In many cases, non-compliance may be wilful (Narula 2005). Even when the guidelines are made operational, complaints committees can be set up to fail their mandate. For instance, a woman employee

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[1] All employers or persons in charge of workplace, whether in the public or private sector, should take appropriate steps to prevent sexual harassment: Supreme Court Guidelines 3.

working in a pharmaceutical company complained of harassment by her boss, yet the committee set up by the management consisted of the boss' associates and the verdict went against the complainant (Kaur 1999). In another case, a university academic reported to institutional authorities that a senior colleague took her to an isolated place on the pretext of regularising her employment status and abused her. Although the enquiry found the allegation to be correct, it was reported that the authorities decided to retain the offender as he held a powerful position in the institution, while the woman lost her job (Ramanathan et al. 2005).

When reviewing sexual harassment in the health sector, most studies from low-income countries mention sexual harassment as part of broader research findings about violence faced by health workers. When examining sexual harassment specifically, studies conducted in medical schools in the USA indicate that responses to instances of harassment often re-victimised the women by blaming their sensitivity or finding some reason to justify such harassment, thereby deflecting attention from systemic gender inequalities that permit the continuation of such forms of behaviour with impunity (George 2007). The scenario in India is no different.

In India, while sexual harassment at the workplace is an unspoken reality, there is hardly any implementation of the guidelines in the health sector. Nor is regulation, more broadly in the health sector, currently effective. The regulatory context of hospital care in India differs widely depending on whether it is in the public or the private sector. Health care in cities like Kolkata is increasingly becoming dominated by the private sector, which consists of a number of large corporate hospitals, smaller hospitals, numerous nursing homes and individual practitioners. Unfortunately, there is no monitoring by or accountability to the people or to any concerned authority. Until recently, only the states of Maharashtra, West Bengal and the National Capital Territory of Delhi passed legislations for private hospitals. However, the Acts are only meant for registration of private hospitals. They do not detail standards to be maintained for space, facilities, staff employed, sanitary conditions, equipment and other supportive services (Nandraj; Khot; Menon 1999). Discussions with authorities further appear to indicate that there

is hardly any monitoring of these regulations. Self-regulation by the medical councils is also very weak. There have been very few instances of doctors being penalised for negligence or for violating the code of ethics. Enquiries on misconduct against doctors are held in secrecy and records are not available (Jesani, Nandraj 1994; Iyer, Jesani 2000).

In contrast with private sector hospitals, government hospitals are monitored by rules and regulations enforced by the state government. Employees are governed through various human resource management procedures that regulate recruitment, transfers, disciplinary action etc. Despite such a formally regulated environment, the implementation of guidelines related to sexual harassment is yet to be given serious consideration.

Occupational Context

The health sector is highly segregated by sex. An analysis of the number of female medical practitioners (allopathic) registered with the West Bengal Medical Council in 2005 shows that out of the total of 48,637 practitioners, 40,864 are men and only 7,773 women (Health on the March 2005-2006). Thus, the ratio of female to male practitioners is 1:5, indicating a wide gap in the number of women and men. In contrast, figures show that there are a total of 28,079 nurses registered with the West Bengal Nursing Council, but only 71 are male (Health on the March 2005-2006).

In my study, nurses working in both the government and private hospitals are either from Kolkata or adjacent districts and come from middle class families. They are nursing graduates and many have also completed post graduation in nursing. During interviews, nurses in the government sector reported that they are posted in Kolkata, the state capital, only after several years of working in the districts. By this time, they are generally married. From profile of respondents interviewed in the private sector, married and unmarried nurses appear to be present in equal numbers.

Whether married or unmarried, nurses in my study reported struggling with various pressures in their personal and professional lives. Many unmarried nurses shared that they had family responsibilities such as the education of younger siblings.

From conversations with the married nurses, it emerged that often they were the main earners, and their income was a necessity for their families. Young nurses in the private sector reported taking loans for their education and required several years of income to repay them. In contrast, conversations with doctors, especially young women doctors in the age group of 22–26 years, indicated that their income was mostly spent on personal expenses, and in case of additional needs, many did not hesitate to take money from their families.

In terms of job security, nurses in the private hospitals I researched, could be dismissed any time, even if confirmed after three to six months of employment. While dismissal is not an easy option for those in the government sector, women workers fear victimisation. At lower levels of the hospital hierarchy, health care attendants in both sectors are employed on a contractual basis, and their services can be terminated at a moment's notice. It is this group that has been most reluctant to share experiences with regards to sexual harassment.

Sexual Harassment in Hospitals

The range of experiences shared by respondents who spoke about women's victimisation is well illustrated by my research findings, which categorise harassment as verbal, psychological and physical (Chaudhuri 2007). These categories are in consonance with the Supreme Court's definition of sexual harassment, which includes 'such unwelcome sexually determined behaviour (whether directly or by implication) as physical contact and advances; a demand or request for sexual favours; sexually coloured remarks; showing pornography; any other unwelcome physical, verbal or non-verbal conduct of sexual nature' (Supreme Court of India 1997).

RANGE OF ACTIONS THAT CONSTITUTE SEXUAL HARASSMENT

- Verbal harassment: namely comments that have sexual overtones, or personal remarks that are humiliating and sexual in nature;
- Psychological harassment: covers two types of non-contact behaviours:

> (a) intimidation and anxiety provoking behaviours, such as insistence on accompanying the respondent, phone calls at odd hours, stalking/following the respondent, staring at her breasts and sending obscene SMS/text messages; and
>
> (b) sexual gestures and exposure, including incidents in which the perpetrator intentionally falls onto a woman, exposes his penis to her, stands naked, masturbates; in the case of patients, insists that female nurses or other female staff members massage or sponge his body or wipe his private parts even when he is able to do so himself;
>
> • Physical harassment which covers unwanted touch, which is of breasts or other parts of the body, and unwanted embraces;
>
> • Rape, attempted rape or forced sex.

A cross-section of men were identified as perpetrators of sexual harassment, including doctors, patients, non-medical staff (stewards, sweepers, peons and ward boys), administrative staff and outsiders to the hospital. Among hospital personnel, sexual harassment was reported to occur between specific cadres and occupational hierarchies. Doctors were identified as harassers by nurses, doctors themselves and by public relations officers. Non-medical and administrative staff mentioned harassment by their own colleagues, while health care attendants named non-medical staff, and patients and their families as harassers.

In government hospitals, patients reportedly intimidate women respondents through words, threats or by their sheer number. In private hospitals, especially the large ones, the profile of patients is different from that of patients of public hospitals, and the patients' power lies in their social and class status. In government hospitals, unrestricted access to premises is a key issue. Apart from family members of patients, a large number of people who may be family members of non-medical staff having quarters in the hospitals, visitors of such families and other unidentified strangers are present within hospital premises, and have no accountability. Such people have been accused of harassment, especially during the night, by nurses, non-medical staff and also young doctors.

Responses to Sexual Harassment in Hospitals

Women workers

Despite differences in occupational and social locations, both female nurses and doctors reported similar kinds of experiences in terms of sexual harassment. What comes across from the research is that female employees are neither aware of the law nor about options for redress. There is, furthermore, an unspoken understanding among them that women have to experience such harassment in the workplace, just as they experience the same in their private lives or in public spaces. Female doctors shared that they have 'learnt to laugh at such incidents' and added, 'saying bad things on seeing a woman is natural'. Some brushed away such incidents by saying, 'it is much less in hospitals than on roads, bus...' Female nurses also reinforced this by saying that they did not let 'such things' affect them — 'only a few do it, so it does not matter'; some said they had become 'used to such things'. These responses indicate that women cope with sexual harassment by normalising or minimising it. When the problem comes from patients, their behaviour is excused on grounds of ill health. As a 35-year-old senior nurse from a private hospital said, 'We do not give much importance to this. We treat them as patients.'

> *Respondent:* *If the patient party is critical we have to run around. At such times the patient party can say anything to whoever is in front of them.*
>
> *Investigator:* *What do they say to you?*
>
> *Respondent:* *We will fuck your mother, we will fuck you.*
>
> *Investigator:* *What do you do when they say such things?*
>
> *Respondent:* *We cajole them, address them as* dada *(elder brother),* bhai *(brother) and calm them down.*
>
> —Health care attendant, female (32), working in a government hospital

Among ad hoc employees and more established cadres, such as doctors, alike, there is also an air of resignation about reporting harassment. Perceptions about reporting are complex,

reflecting fear, shame and reprisal. Many women realise that they should complain, yet do not for fear of consequences.

'We are not even allowed to do anything in a group. The management feels this can be a cause for agitation. Once it happened that a group of nurses had gone to the management with some demand, all of them were suspended.'
— Middle-level nurse, female, age 28 years, private hospital

'You cannot complain too much, you will be marked as a trouble maker.'
— Middle-level nurse, female, age 32 years, private hospital

Respondents themselves were aware that their reluctance to use a formal mechanism, and the authority's reluctance to act impartially when a formal complaint is filed, have resulted in the continuation of the practice of sexual harassment.

'We keep quiet and adjust to the situation, and in this way these incidents keep on increasing.'
— Junior doctor, female, age 28 years, government hospital

Among those who made an initial complaint, there was reluctance about providing the complaint in writing. There was also apprehension about not being able to furnish physical evidence towards substantiating the charge:

'I did not have any proof; I did not think I would be taken seriously.'
— Middle-level nurse, female, age 27 years, government hospital

When women did report instances of harassment, hierarchy among hospital staff was an influencing factor. Where male doctors are perpetrators, experiences of harassment are far less likely to be reported than when other men harass women. Female doctors rarely reported cases of sexual harassment, and when they did so, it was not against male doctors but against male non-medical staff and others lower in rank. Similarly, female non-medical staff seldom lodged complaints about their male colleagues. It appears that complaints are made more often when the harasser is junior in hierarchy to the complainant. A

complaints mechanism was not constituted at the time of the study in any of the four hospitals, and none of these reported complaints were looked into as per the Supreme Court Guidelines.[2]

Support rendered by male colleagues

Men reported that they come to know of occurrence of sexual harassment when their women colleagues shared their experiences with them. Senior men came to know of such instances when there had been an official complaint, or when they had been asked to intervene by the woman concerned. In instances where women colleagues shared their experiences with their male colleagues, the latter took different kinds of action, ranging from asking the woman to avoid the harasser, scolding the harasser, to physically beating him up.

> '*A female doctor was being disturbed by her colleague. When she shared this with me, I went and slapped the harasser.*'
> — Middle-level doctor, male, age 43 years,
> private hospital

> '*A nurse complained to me about a patient who would untie his pyjamas whenever she passed and then asked her to tie them up. I rebuked the patient.*'
> — Middle-level doctor, male, age 36 years,
> private hospital

Male colleagues added that when women did not accept harassment, there were repercussions, where the abuser embarrassed the women in public or created work related problems.

> '*Even in the government sector, proposals are made. If the woman does not agree to such proposals then she is transferred. This happens mainly by those who have power.*

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[2] The Supreme Court Guidelines stipulate that 'an appropriate complaint mechanism should be created in the employer's organisation for redress of the complaint made by the victim. Such complaint mechanism should ensure time bound treatment of complaints'. In spite of the guidelines reluctance to constitute complaints committees is universal (Chaudhuri 2008). Experience of supporting women seeking redress reveals that getting the complaints committee constituted to inquire into a specific complaint requires sustained advocacy.

*Those at the administrative level exploit people. They can
pass any file and do things that otherwise wouldn't have
been possible.'*
— Senior doctor, male, age 50 years, government
hospital

Men also spoke about inability of the women to take action.

'*A male non-medical staff, aged around 50, was repeatedly
touching a health care attendant while talking to her in
the cabin of a patient. A sister and I were standing there
at that time. After he went away, I asked the girl, "do you
know this man from before?" The girl said, "I am
acquainted with him through work." I asked her, "he was
touching you all the time, why did you not say anything?"
The girl said, "What will I say, this happens all the time,
what is there for me to do?"'*
— Ward master, male, age 52 years, government
hospital

Support from supervisors

Actions taken by supervisory staff, whom nurses usually
confided in or complained to, varied. For most part, it was clear
that they would advise that the matter be resolved at their level,
without involving senior management.

'*We can sort out such small issues, it is not right to trouble
the management over every little issue.'*
— Nurse (supervisor), female, age 35 years,
private hospital

'*Instead of complaining to those at higher levels, we try
and sort out problems. If they (the accused) have to leave
based on our complaints then we will suffer. All private
hospitals are short staffed and we will be burdened further.'*
— Nurse (Supervisor), female, age 31 years,
private hospital

Some clearly put the onus on the young women themselves.

'*I would like to say one thing; the kind of provocative dress
that girls wear will make boys look at them. If girls are
properly dressed, are polite in their manners then there will
be no harassment. Girls, who encourage boys, face*

*harassment. We have to be OK from our side; it is no use
blaming boys.'*

— Senior nurse (supervisor), female, age 37 years,
private hospital

*'Actually there is no scope of anything like this happening
here, as during the hiring process they (women nurses) are
told to behave properly. If there is a new junior girl, I
observe her. If there is anything untoward in her behaviour,
I take steps. I will inform the department head if it is
necessary.'*

— Nursing head, female, age 52 years, private hospital

Actions taken were by and large non-confrontational. The
most typical action was to ensure that the victim was not placed
in a similar situation again. For example, nurses (the majority
of those who complained) reported that when they had
complained to a nurse in a supervisory position about
harassment by a doctor, the nurse would help her keep a
distance from the harasser. In one case, a nurse in a supervisory
position had requested the perpetrator doctor to interact with
another nurse. In cases of complaints of harassment by patients,
nurses were advised to visit the patient in a group or, more
commonly, together with a nurse in a supervisory position.

*'Once a young patient pinched a nurse on the bottom while
she was attending him. She brought this to the notice of
the concerned consultant. He discharged the patient as soon
as possible. She handled it intelligently; if a nurse weeps
and creates a scene, there is every chance that the patient
will complain against the nurse. Then the management will
have to listen to the patient.'*

— Nurse (supervisor), female, age 31 years,
private hospital

Direct confrontation was rare. In a few cases, senior nurses
personally supervised interactions between patients and nurses
who complained of harassment. At times doctors intervened.

*'Nurses have complained that patients have lifted their
lungi (a wraparound). When they come and tell me
something like this I go and talk with the patient.'*

— Senior doctor, female, age 41 years, private hospital

Respondents noted that these responses only provided short-term respite, and incidents of harassment kept recurring. As one victim reported, when action was taken, the harasser stopped harassing her but continued to engage in sexual harassment of others. The same was reiterated by supervisors themselves.

> *'He did not do anything to me after that, but I know he has been troubling others.'*
> — Administrative staff member, female, age 27 years, private hospital

> *'Nurses complain to us. We have spoken directly to these doctors. Some change...some do not. We try to make sure that the juniors are not alone.'*
> — Nurse (supervisor), female, age 37 years, private hospital

Immediate superiors are often not vested with the power or authority to deal with such issues. They themselves neither raise the issue with authorities nor urge them to take action on such matters.

When asked about the benefits of instituting complaints committees, some respondents felt that a committee would enable a woman to come forward and complain in case of sexual harassment. However, others expressed doubts about the proper functioning of such a committee.

> *'Yes, but it is also necessary to give importance to things like who will run the committee and whether they will take up the responsibility. Incidents are increasing in our country. If you check the newspapers, females aged 8-30 are being harassed. If there is a committee then people will be afraid to do these things, such incidents will be less. It is especially required in the districts, as there we have to work in a very insecure environment.'*
> — Senior nurse, female, age 43 years, government hospital

> *'No, the management will not allow it to work. See, this may be a hospital, but it is also a kind of business; why will they trouble themselves with an extra burden. What I want to say is that they will make a committee for*

decoration, for publicity sake, but will not allow it to work,
as an independent body.'
— Middle-level doctor, male, age 37 years, private
hospital

The issue of dealing with patients who harass becomes more
complex in the private sector in the context of the following
statement:

'Patients are everything. This hospital has a policy that
each HOD (head of Department) is given a revenue target.
He has to fulfill the target and cannot afford to say anything
to the patient.'
— Middle level doctor, male, age 39 years, private
hospital

Unions and associations

In government hospitals, there is a separate union specifically
for nurses. Since only women are employed as nurses in
government hospitals, these unions are constituted entirely of
women. However, very few nurses are active in union activities.
Lack of time was cited as a factor; '... as soon as duty is over,
we rush out, go home. We do not get time to sit and chat.'

Investigator: Are you a member of any association?
Respondent: Yes, I pay subscription, that's all. I don't attend
meetings or go for processions.
— Senior nurse, female, age 45 years, government
hospital

In the private sector, while non-medical staff in some private
hospitals have unions, which are dominated by male employees,
female nurses in private hospitals in the city are not affiliated
to any union, and are hence bereft of spaces to network or
address issues of concern. The impact of this non-participation
is realised and articulated by female nurses themselves.

'Once there was a problem between a lady clerk and a non-
medical staff. She complained to the authority. The boy
was suspended but immediately reinstated on demand by
the union.'
— Junior nurse, female, age 27 years, private hospital

While male doctors belong to different associations, female doctors do not seem inclined to make their presence felt in such forums. In fact, female doctors repeatedly said that they were not interested in politics and did not believe in the ability of the unions or associations to solve their problems.

'The boys in my class are members of association. But I do not have any discussion related to associations with them. I have avoided such associations completely,' said a 24-year-old female student doctor at a government hospital.

> *Investigator: Are you a member of any association?*
> *Respondent: I am apolitical. I am not associated with any kind of association. Because all associations try to take advantage of you without giving any advantages.*
> — Resident Medical Officer, female, age
> 43 years, government hospital

Men from doctors' associations reported that it had never occurred to them that sexual harassment could be an issue of concern, nor had women ever shared such incidents with them. Most were not aware of the Supreme Court guidelines. Some had heard of it by name only.

> *'We have never got any complaint. No woman has approached us with this problem. So we have never tried to asses whether women are aware or not. You are the first person with whom we are talking about this issue. I must say, it never occurred to us as an important issue.'*
> — Senior doctor, male, age 51 years, government
> hospital

Senior male members of unions echoed the authorities, when they said that sexual harassment did not occur in the government sector and such behaviour did not coexist with trade union ideology. They negated the need for any actions or awareness on the issue.

> *'See this is not an economic policy that it has to be implemented immediately, it is cultural, these things are coming because of the influence of American culture.'*
> — Senior union officer, male, age 45 years

> *'The complaints committee will be constituted, only when there is a problem. This issue is not on our agenda, we have never experienced the need for it.'*
> — Union officer, government hospital

Response from authorities

Those in senior managerial positions in the private sector expressed apprehension about the issue and the belief that women need to know how to avoid such situations.

'I have to think of all possibilities. If my secretary does not like me, she can make a complaint of harassment against me. She may use this. We have to think of ways of dealing with this. How do we prove this? We have to be careful about not becoming biased against men.'
— CEO, male, age 45 years, private hospital

'Women need to be responsible. They should get out of the mindset that they are the weaker set. The situation goes through a series of phases before it becomes serious. If the other party (women) is not agreeable then the situation cannot go far.'
— Senior medical doctor, male, age 52 years, government hospital

The modus operandi of authorities in dealing with multiple competing priorities is revealed during the following conversation with the head of a government hospital:

'I cannot say that it (sexual harassment) has not happened. This is such a huge hospital; it is unnatural if such incidents have not happened. Whatever is happening all over the country must also get reflected here. But it has never come into priority, whenever there is a crisis government jumps into that; action is taken only when the crisis is precipitated. This is my confession, there are so many crisis areas to be looked into, if this becomes a crisis then I will look into it.'
— Authority, male, age 54 years, government hospital

Authorities said complaints were usually referred to immediate superiors. Nurses on the other hand reported that their immediate supervisors were not always encouraging about such issues. And nursing superintendents on their part said they had never been encouraged to deal with sexual harassment nor did they have any information about how to deal with it.

Denial is an overriding factor cutting across sectors. Reasons cited for disbelieving the complainant cited by senior management included - 'harassers come from good family background and hence cannot commit such acts', or '...we have not received any complaints so far. Our culture is like that...we are like a family'. It was repeatedly stated that such incidents would be less frequent in this profession as medical students were highly educated, and that they were so familiar with the female body that such things did not excite them.

Regarding harassment of women doctors, those in positions of authority were disinclined to accept that they may experience harassment. This was said on the assumption that 'doctors enjoy the highest position in the hospital and social status'. Many of those in senior positions added that women were adept in handling the issue of sexual harassment, and there was no need to initiate formal mechanisms to prevent it.

'I do not believe that only men are responsible. Women are responsible too. They provoke a man. A woman provokes in many ways. It can be done physically, through physical gestures (sharirik anga bhangi), through her dress or behaviour.'
— Union leader, male, age 56 years, government hospital

'There is a give and take policy in every relation. Women I believe can handle such behaviour quite efficiently.'
— Manager, male, age 52 years, private hospital

Concern about the need for evidence was repeatedly expressed, thereby corroborating the concern articulated by women employees, that in the absence of proof, it is advisable to keep quiet.

'They (women) must have evidence. Otherwise anyone can say anything to anyone.'
— Manager, male, age 47 years, private hospital

'One hears such things but there is no evidence.'
— Senior union member, male, age 51, government hospital

These conversations reveal that along with a disinclination to accept that sexual harassment may occur, there is an apprehension that women may misuse the guidelines. Absence of evidence to substantiate complaints is a key area of concern.

Further, those in positions of power repeatedly emphasise that women are adept at handling such situations and should take the responsibility of doing so.

Conclusion

In conclusion, this exploratory study revealed a number of viewpoints about sexual harassment, from different actors working in four Kolkata hospitals. Despite representing different regulatory environments, health workers, their colleagues and seniors, narrated comparable experiences, and expressed similar opinions with regard to sexual harassment across both government and private sectors. While formal regulations make termination of services in the government sector very difficult for some, apprehensions about victimisation and reprisals through transfers and others means are very real. In the private sector, where formal procedures may not exist and existing regulations rarely enforced, talking about sexual harassment is perceived to be bad for business. Generation of revenue takes precedence over all other concerns.

Many of the responses pose challenges to the implementation of the guidelines at various levels. Firstly, women themselves are unlikely to complain as they tended to normalise or minimise instances of sexual harassment and absolved patients for any incidents due to their ill-health. There were also considerable apprehensions about reporting incidents of sexual harassment. Male colleagues and immediate supervisors confirmed that due to reprisals from management or backlash from the perpetrator, victims of sexual harassment could put themselves in worse trouble by reporting incidents. In reflection of these power dynamics, the few incidents where harassment was reported were when perpetrators were subordinate to the victims.

Despite the ways in which sexual harassment is normalised, and the challenges in reporting the problem, colleagues are not necessarily apathetic to the problem.

Both male colleagues and supervisors reported intervening on behalf of women health workers. Responses were usually non-confrontational, although in some rare instances, more direct interventions were reported. However, these responses were recognised by respondents as being primarily temporary

solutions that did not prevent repeat incidents, or other women from being victimised by the same perpetrator. Respondents recognised the need for broader organisational responses and, at the same time, were sceptical about how they would be implemented.

While there was recognition of the problem of sexual harassment by both women and male workers, and their supervisors, unions and management authorities were less likely to acknowledge the problem. On further probing, various problematic assumptions hampered recognition by these more senior actors. Authorities, those at the helm of unions and associations, and senior personnel felt women were able to handle such situations instinctively, and, therefore, did not need any support. Respondents also felt that sexual harassment occurred when women gave encouragement in lieu of benefits. Therefore, they held women liable.

What is required, therefore, are implementation mechanisms that recognise the obstacles posed by power imbalances and gender norms that allow continuation of sexual harassment in public and private hospital environments, and also deter women from making formal complaints and receiving appropriate redress. Such mechanisms need to create awareness amongst workers and managers alike. More specifically, training women on the modalities of making a complaint and taking it forward, proper orientation and training of inquiry committee members, creating a context wherein impartiality is ensured, along with accountability of the authorities towards the redress process are needed. For all these, further directives, implementation strategies and strong monitoring mechanisms suitable for the context of the health sector need to be articulated.

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Gender and Health Training of Male Multipurpose Workers

Challenges and Lessons Learnt from Mumbai

Anagha Pradhan, Renu Khanna and Korrie de Koning

Male health workers can link together men in need of reproductive health services, their partners, and health care providers (Piet-Pelon et al. 1999). Despite this potential role, identifying model programmes regarding male health workers is not without challenges. It is a common observation that male workers possess less information than their female counterparts. Furthermore, training and discussions with male workers reveal a range of concerns and apprehensions regarding sexuality, pregnancy, abortion and infertility (Raju & Leonard 2000). Lastly, there does not appear to be much experience in South Asia in training male health care providers on issues of sexuality and health, especially from a gender and rights perspective (Hawkes 2000). Reflecting on this gap, this paper describes the experiences of the Women Centred Health Project (WCHP) in training male health workers[1] in the Public Health Department (PHD) of the Municipal Corporation of Greater Mumbai (MCGM) on gender, sexuality and health.

The project evolved from a research study on factors predisposing women from weaker socioeconomic strata to pelvic inflammatory diseases (PID). Women's lack of power to negotiate responsible sexual practices with their male partners was found to be one of the factors. Women study participants suggested that the public health care system should assume a greater role by reaching out to men and conveying to them the importance

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[1] The male health extension workers trained consisted of multipurpose workers (MPWs) and Community Development Officers (CDOs).

of men's role in women's reproductive health. The WCHP was started in 1996[2] to translate learning from the PID project into practice. Enhancing the public health system's outreach to men, with the aim of increasing men's responsibility in women's reproductive health, was one of the objectives of the project.

WCHP (also referred to as 'the project' in this chapter) was a collaboration of the Public Health Department of the MCGM, Society for Health Alternatives (SAHAJ), and Royal Tropical Institute (Amsterdam). The project focused on capacity building of municipal health care providers for providing gender-sensitive, quality reproductive health care services through the municipal primary health care facilities, namely the health posts and dispensaries. To increase men's involvement in women's reproductive health, the project focused on male multipurpose workers (male health workers), who are the only cadre of male outreach workers in the PHD of the MCGM.

This chapter draws on the information gathered over the duration of the project through exploratory research, documentation of various meetings and workshops with health care providers, and interactions with male health workers. At the onset of the project, baseline studies were carried out to understand health care providers' perspective towards women's health. The baseline study findings provided the basis for a number of workshops with grassroots health care providers, including male health care workers. Discussions during the workshops were documented and analysed to identify the key themes discussed, and the attitudes of the participants. A 'men's involvement committee' was formed after a series of workshops, exclusively comprising male health workers and their male supervisors. Participation in the committee was voluntary. Committee members discussed various issues around incorporation of gender-sensitive reproductive health into the

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[2] Women Centred Health Project (1997-2002) was implemented as a pilot project in two of 24 administrative wards of the MCGM with a population of 1.2 million, as per Census 2001. Reaching out to men in the community was beyond the scope of the project with a small team of 15 persons. In view of the enormity of the population in the pilot areas, as well for ensuring sustainability of interventions beyond the project period, WCHP focussed on health care providers as change agents. Capacity building of health care providers was a major component of WCHP.

public health system, and developed a module for health and sexuality training of adolescent boys. All interactions with the male health workers — as participants in the research, workshops or as members of the committee — were documented in detail. Interviews with male health workers and male community development workers for the mid-term and end of the project evaluation also provided information on male health workers' perspectives on the project's activities.

While the project designed activities to increase men's involvement in women's reproductive health, the team was careful to ensure that working with men should not result in women further losing control over their bodies or decision making. Even though the project conceptually recognised men's own reproductive health needs, for operational reasons, we defined 'men's involvement' as limited to their role as partners in women's health. The project provided male health workers with a more comprehensive understanding of the way notions of masculinity and male sexuality influence individual ideas, perceptions and behaviour. Through discussions, case studies and participants' experiences, the inter-linkages among gender, patriarchy, power and reproductive health were placed at the centre of all capacity building of the male providers.

Men's Role in Women's Health: The Broader Picture

The feminist movement, and the International Conference on Population and Development (ICPD 1995) prioritised women's right to health and decision making about her body. In order to address the gender inequalities that undermine women's rights, the ICPD agreed that men should be encouraged and enabled to take responsibility for their sexual and reproductive behaviour, and to play a more active role in family planning and child-rearing. ICPD stated that changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving a harmonious partnership of men and women (ICPD 1995).

Unequal power relations in the male-dominated Indian society affect all aspects of women's lives, including their sexual, reproductive and general health. Research in India shows that poor women carry a heavy burden of reproductive morbidity (Bang et al. 1989; Bhatia & Cleland 2001; Koenig et al. 1998);

a significant component of women's health which is unrelated to pregnancy and is due to reproductive tract infections and sexually transmitted infections (RTIs/STIs). As men's attitude and behaviour affect women's reproductive health (Piet-Pelon et al. 1999; Raju & Leonard 2000), unless men are involved, programme efforts will have limited impact (Pachauri 1999).

Research in the past decade demonstrates that involving men, by way of orienting them to the gender and sexuality aspects of women's reproductive health, positively affects women's reproductive health. *Pati Sampark* (literally, 'contacting the husband') programme in rural Gujarat in India showed that in the project area where men were contacted, women had a more in-depth understanding of antenatal care as compared to women whose husbands had not been included in the programme (Raju & Leonard 2000). Substantial evidence shows that involving partners in counselling for family planning, STI treatment, and HIV/AIDS testing and counselling is more effective than addressing women on their own (Kwaak van der A et al. 2007). Not only do programme managers want to involve men to improve the effectiveness of their programmes, but women also request that their husbands be contacted and sensitised about how their behaviour has a bearing on the reproductive health of their female partners (Raju & Leonard 2000; Khanna et al. 2002).

Paying attention to men's roles in sexual and reproductive health is important for gender equality and women's health, but also because men have a range of vulnerabilities and sexual and reproductive health needs of their own (Kimmel 1999). Socially prescribed gender roles and identities do not only give men power and privileges, but also make them vulnerable. Discussions with village men and youth in Gujarat revealed an unsuspected degree of vulnerability among men, leading to the observation that 'just as women need to liberate themselves from the stranglehold of patriarchy, men too need to free themselves from the patriarchal construct of masculinity' (Khanna et al. 2002).

In Bangladesh, 42 per cent of those who attended male health clinics complained of psychosocial problems like premature ejaculation, impotence and so on (Hawkes 1998). A study in Gadchiroli district, India, involving 600 males aged 15 to 44

years, found that 82 per cent suffered from reproductive and sexual complaints. They ranked these as the most serious complaints of males (Bang et al. 1996). Despite such high prevalence and perceived seriousness of male sexual and reproductive problems, 73 per cent did not receive any care for their complaints (NFHS 2001). Verma et al. hypothesise that men's sexual health problems adversely influence the quality of family life, discourage men from using contraception, and may result in domestic and sexual violence (Verma et al. 2000). Despite the emerging evidence about male sexual and reproductive health, and its links to gender relations and female sexual and reproductive health provider biases often remain an obstacle in the promotion of male contraceptives (Helmer & Roitstein 1995).

Lessons From the WCHP Experience

The situation in the beginning...

Male multipurpose workers, along with their female counterparts (also known as Auxiliary Nurse Midwife or ANM), are the first cadre of professionalised health care providers staffing the sub-centres in the rural health care delivery system, and the health posts in the MCGM's Public Health Department[3]. After high school, a male worker is given six months' training in public health. With virtually no scope of in-service training, low motivation, high absenteeism and over 60 per cent of the posts lying vacant, this cadre is the most neglected.

Male health workers in Mumbai are between 30 and 40 years of age, most have 12 years of formal education — that is, up to high school — with around 10 years of service in the MCGM. Most are from the lower middle class, and are married for more than five years. In the MCGM's Public Health Department, the male health workers occupy a low position. Placed at the most peripheral of the health care delivery centres (the health posts), male health workers share large part of their responsibilities

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[3] PHD of MCGM has both male and female multipurpose workers. The number of female MPWs is very small and their duties are similar to those of the auxiliary nurse midwives. WCHP's work related to men's involvement in women's health was carried out with male multipurpose workers only. The term MPWs is used in this paper to refer to male multipurpose workers.

with auxiliary nurse midwives (ANMs), who are better trained in health issues as compared to the male workers. The ANMs and male health workers are supervised by a Public Health Nurse, a medical officer who is usually female. Male health workers supervise female community health volunteers/workers. In the context of the MCGM's Public Health Department, male health workers' roles in reproductive health are limited to the promotion of vasectomies and distribution of condoms. In general, male health workers share with ANMs the responsibility of the implementation of various national health programmes, such as the Extended Programme for Immunisation, the Revised National Tuberculosis Control Programme, National Leprosy Eliminatic Programme and anaemia control programmes.

The project was aware that attitudes at work are an extension of attitudes in personal lives, and to influence work practices, it is important to understand the views health workers hold as 'persons'. Therefore, a series of exercises were carried out at the beginning of the project to understand male health workers' views on sexuality, on men's role in reproductive health, and on the role they saw for themselves in reaching men.

For example, male health workers were asked to complete sentences that would reflect their views about 'being a man'. The following responses show the concern of the male health workers about their own image as men:

Men cannot do: *'cooking and household chores'.*

Men are ashamed: *'if they are insulted by women (or if they lose face in front of women)', 'if they have RTIs/STIs', 'if women do their (men's) work', 'if they (men) have to cook'* or *'if they cry in presence of others'.*

The same group believed that women want men to: *'look after them', 'understand them', 'cooperate with them in everything', 'to help in household chores'* and *'to be loyal to them'.*

Interviews were conducted with men and women from the community (people who lived around the health posts and were users of municipal services) to explore the possible role male health workers could play in increasing men's involvement in women's reproductive health. Interviews with women who had experienced a reproductive health condition in the recent past and their husbands showed that one-third of the women (four of 14),

and more than half of the men (six of eight) interviewed were not provided with any information about the procedure(s) that the women underwent. All men interviewed for the study knew of their wives' health condition. However, they appeared to 'normalise' these problems as something that happens always or to all women — '...she had a severe backache, but it was normal and was cured after treatment'; '...delivery was caesarian and was normal'.

In another exercise, male health workers were asked whether they felt it necessary to increase men's involvement in women's reproductive health, and the role they saw for themselves in this regard. The responses show the internalised, gender stereotyped values of the male workers. They see the role of men in terms of the husband as 'benefactor', express the pressure men may feel in being providers, and see the role of women to serve their husbands. One MPW stated that he would like men to take the initiative in contraception — ' ...women get married at a tender age and give birth to one child every year if the man does not take initiative'. Another reason cited for involving men was, 'when in good health, women can look after household duties'. One MPW opposed the idea of involving men in women's reproductive health, '...men work like bulls and it is not fair to expect them to look after all aspects of life'.

These statements highlight that the male health workers were responding from their perspective as partners and men, rather than approaching couples from a gender-sensitive health care provider perspective. This insensitivity towards the rights of clients is not limited to women but extended to some men from the community. One MPW reported motivating a man for acceptance of contraception 'if he belonged to socio-economically weak household or was unemployed, or had addictions'.

Male health workers reported a number of obstacles in carrying out their primary role of motivating men for family planning. During interviews, the male health workers reported few opportunities for interacting with men, primarily because their work hours coincided with the work hours of most men from the community. Male workers tried to overcome this obstacle by talking to fathers accompanying children for immunisation, although this is not an ideal moment to talk with men about sexual and reproductive health issues. Some male

health workers felt that the attitude of men towards them limited their opportunities for working with men. According to male health workers, men either 'looked down upon them and made fun of them' or 'dismissed them and disregarded their advice regarding contraception'. In general, extension workers found men to be unresponsive and 'with closed minds' as far as advice for contraception was concerned.

Disseminating information regarding contraceptives to men was a key responsibility of male health workers. Their inability to do this successfully could be due to a variety of reasons, including possibly the non-receptive behaviour of male clients. In the period prior to WCHP interventions, male health workers did not receive training in communication regarding reproductive health, or on counselling men on use of contraceptives. Their low position in the clinical hierarchy, their own belief and value systems that were rooted in patriarchal notions about masculinity and importantly, the lack of guidance on dealing with sensitive issues, resulted in male health workers' reluctance in approaching males about contraception use. We believe that this reluctance stemmed partly from their low self esteem, since after the sensitisation workshops about sexuality and masculinity, the WCHP counselling training, and with support from trained counsellors, many male health workers demonstrated improved counselling skills.

Interventions with male health workers

The project viewed health care providers as potential change agents. However, male health workers, as representatives of a highly male-dominant Indian society and as staff placed on the lower rungs of a hierarchical clinical system, felt threatened by the approach of the project. In the initial phases, male health workers resisted the training programmes. Fear of an 'additional burden of work' was the reason given for refusing to participate in the workshops. Male health workers also accused the health system of ignoring health needs of men in the community, and the project team of continually reinforcing the 'women centred' perspective and thereby excluding men.

To accommodate the feelings of insecurity, develop the self esteem of the male extension workers and show trust in their capacity, the project emphasised the importance of their ideas

and observations. The training programmes were aimed at reflection and transformation on their role as individual men, as sons, husbands and fathers, and as health care providers.

Five workshops were designed to combine theoretical aspects with practical skills. A total of 33 male health workers participated in the workshops. The content of the training workshops were later documented in a training manual.[4] Through the exercises during the workshops, pre-post tests and informal interactions following the workshops, the project team developed an understanding about key factors in value clarification and transformation of male workers in relation to sexual and reproductive health. The experience provided lessons regarding the methodologies that could be used for working with male health workers.

The initial resistance to the training programmes subsided when two medical doctors and two male facilitators with field experience of community organising and of imparting health education to men were invited as resource persons. These trainers were excellent role models as gender-sensitive men. It was observed that the male health workers could identify with their experiences and were more engaged in discussions.

Different exercises were required for discussing issues around gender and health with men and women health workers. While with women health workers, personal experience sharing was a good starting point in training on gender and health, arguments supported by evidence — statistical or in the form of experiences from other parts of the country and the world — were more acceptable to the male health workers. Male health workers were open for group work and discussion after the rationale was provided based on evidence.

In the initial phases, male health workers objected to role-plays used in the workshops. In a later phase, exercises such as 'power walk',[5] group work on 'effects of patriarchy on men and

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[4] See 'Working with men: Gender, rights, sexuality and health — trainers' manual' published by SAHAJ, Baroda, 2005.

[5] Power walk is a simulation exercise designed to get participants to identify various basis of power linked to identities and to experience feelings of powerlessness associated with identities such as an old man without resources for survival, a young woman with a low salary job, a youngest brother in a highly patriarchal joint family etc.

women', and discussion on contents and messages given through 'non-veg' jokes[6] were useful in initiating discussions with male health workers. Films were also effective in initiating dialogue.

Examining views on gender relations

The starting point of the process of understanding gender was a critical reflection on commonly held views, facilitated by male facilitators. In a discussion based on case studies from other parts of the country, extension workers would agree that women bore a higher burden of chores, that this was shaped by the traditional male-dominated society, and that men should share responsibilities related to house-keeping and child-rearing. But when it came to discussing their own role at home, or the role of men in the communities they worked with, they turned to generalising the context rather than examining their own home situation: 'In Mumbai, both men and women earn and men help at home; the situation in backward areas of the country really needs some improvement'.

In the first workshop on gender and health, following a discussion on violence as a gender and health issue, the participants tried to justify domestic violence. They argued that violence against men is common but unspoken: 'Violence against men is different and hidden. If a woman does not cook and serve her husband properly, it is violence against him'. This example shows that male health workers' perception of violence against men is based on existing gender stereotypes, and as discussed by the facilitators, the notion of women not cooking as an act of violence against men arises out of the societal norms of a patriarchal society. Participants were provided the space to share their own experiences of violence against them. On examination, the group could not come up with one genuine example (experienced by the participants) of victimisation of men by women. Later, this discussion was used to contextualise the gendered nature of violence against women.

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[6] The term 'non-veg' jokes refers to sexual jokes which, in this context often consisted of indecent innuendos about women's reproductive organs. The facilitators discussed these to bring forth the male health workers' attitude to trivialise women's reproductive health and men's insecurities reflected in absence of any light-hearted reference to male reproductive organs.

Outcome of the gender sensitisation efforts of WCHP

Interventions by WCHP influenced male health workers in two important ways — first, the inputs helped them change/revise their understanding about gender and men; and secondly, they clearly saw a role for themselves in discussing gender, sexuality and health with their male clients.

Male health workers expressed their changed understanding through a number of ways. For example, following the initial workshops on sexuality and reproductive health, 11 out of the 33 male health workers volunteered to be part of a 'men's involvement committee' to discuss the potential role of male workers in the Reproductive and Child Health Programme of the Government of India, and strategies for men's involvement in reproductive health in institutional settings. The committee met regularly for three years. Over time, it became a forum for discussing problems related to implementation of their gender and sexuality related learning. Further training needs were identified and ideas related to masculinity and reproductive health were discussed in the meetings of the committee. Male health workers from the non-project areas were attracted by these discussions and the group became larger. The committee evolved into a 'space' for male workers to explore new expressions of masculinity.

The changed views were also apparent in the male health workers' documentation of their experiences of the learning process and exposure to concepts like gender, sexuality and patriarchy. Some of these reflections were converted into articles and published in a periodic newsletter brought out by the project. Reflecting on a particular workshop, one participant wrote, 'The session on "Trust" gave me experiences that will remain with me forever.' Another write-up was about an animated discussion following the screening of a feature film 'Astitva'. This film depicts the double standards around male sexuality that exist in society.

In another informal discussion, following the gender and health workshop where violence as a gender issue was discussed, one MPW said that before the workshop, he believed that some women get raped because they bring it upon themselves; but after participating in the workshop discussions, he began to carefully examine the reports in the newspapers. He said he

realised that in most cases, the woman is powerless — she is either too young or too old, or in an environment unfamiliar to her, or is raped by men she trusts. This understanding is still a far cry from accepting that there is never an excuse for violating another person's body, but a step in that direction nonetheless.

Self perceived changes in views around gender, sexuality and health were apparent in the discussions and interviews carried out as part of the end-of-the-project evaluation. Two male providers expressed that their participation in a workshop on communicating about sexuality in the community (Stepping Stones Workshop) resulted in changes in their relationships with their wives. Communication between couples increased, as did their sensitivity to their partners' needs (including sexual needs), and they started giving them increased emotional support — 'I became more sensitive to my family's, including my children's, perception of me'. These personal changes were reflected in their work as key trainers. One of them shared how he felt safe enough to speak of his own dilemmas in the training that he conducted. He could share his own experiences of bringing about changes in his own relationships. This confidence in turn helped dissolve the inhibitions of the trainees.

In focus group discussions during the project evaluation, male health workers reported that they realised the role that they can play towards gender equality. They said that the training workshops had taught them that women are not weak. Through the workshops they realised that men and women are equally constrained and trapped by traditional role prescriptions — '*Stree bhi peedit hai, purush bhi peedit hai* (Women are affected (by the system) and men are affected too!)'. Men have the pressure to be 'masculine' — 'they cannot cry or express their emotions because they would be labelled *baaylaa* (effeminate)'. They could begin to apply their gender understanding to the client-provider relationship and women's health. 'Doctors have a medical opinion about pregnancy and the possibility of sexual relations during pregnancy. But women's feelings about this must be acknowledged. It is not sufficient to go only by a clinical opinion' (WCHP 2005).

Subsequent to the training workshops, male health workers saw an important role for themselves in providing information

to men. They said that they could talk to men and 'help them understand women's perspective', and believed that providing information on abortion and contraception to men waiting at a hospital outpatient department, and development of information, communication and education material for men on these issues, could be good entry points for male health workers to initiate work with men. Acting on this suggestion, the project provided training in counselling to some of the male health workers, who successfully provided information and counselling to 180 men who accompanied their partners to the gynaecology clinic in a secondary hospital.[7] Some male health workers successfully carried out health education sessions on reproductive tract infections for men in the community, although they reported having problems contacting men during their own working hours as the men were also away on work. Some formed groups of adolescent boys and held health education sessions, which were more successful.

Through their extensive interactions with men during the counselling sessions, and in the course of group health education sessions, male health workers gained insights into the specific health needs of men. They reported that men prefer male doctors, and providing clinics with male doctors that ensure privacy and confidentiality is necessary to encourage men to seek reproductive and sexual health services.

A male health worker shared how he became more client-centred after the training. His counselling of the hotel boys who visited sex workers improved, and, as a result, the hotel boys, a closed group, became more open. He reported that there was a reduction in the number of boys who went back to sex workers.

Although initially resisting discussions on gender and sexuality, male health workers later took the lead in developing a health education module for adolescent boys that would discuss the very same topics. Four male workers volunteered to develop a manual on sexual and reproductive health to sensitise out-of-school adolescent boys on gender, sexuality, and reproductive

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[7] Between 2000 and 2006, the WCHP ran a counselling centre within the Gynaecology Clinic at the VN Desai Hospital, a secondary hospital of the Municipal Corporation. Between January 2001 and December 2002, MPWs counselled 180 men accompanying their partners to the gynae clinic.

and sexual health. Convinced that gender and sexuality are essential components of health education, male health workers suggested a variety of exercises to be used with adolescent boys. They asked for reading material and did a self-study, and developed various modules. Subsequently, they presented the draft manual to a group of experts for feedback. During a discussion on whether a separate module should be developed on gender, one MPW repeatedly stressed the need to discuss gender aspects for each of the topics included in the manual, such as nutrition, physical exercise and games, sexuality etc.

As mentioned earlier, working with male health workers was an uphill task, and the project succeeded in getting a foothold only after many trials and errors. The activities involving male health workers gained momentum in the last two years of the project. Though documentation was maintained, the period was too short to demonstrate any quantitatively measurable impact on the work of the male health workers. However, a review of contents of counselling to men (usually partners of women seeking services at a gynaecology outpatient department at a secondary hospital) showed that the trained male health workers provided men clients with information on the women's health status, possible roles the men partners could play (e.g. 'she needs rest'/ 'you must make sure that she gets some rest for a few days'/ 'she is weak, her body needs nutrition, you should take care that she eats well' etc.) and addressed any queries their male clients asked. It was also noticed that with a male counsellor at the counselling centre, many men came in to ask questions related to their own health as well.

Discussion

There is growing acceptance of the involvement of men as partners in women's sexual and reproductive health, and for their own sexual and reproductive health needs as well. Strategies for working with men in diferent contexts are being experimented with. This chapter presented an example of what it takes to address men as gendered and sexual beings. Gender sensitisation of male health workers was a difficult process — for male health workers because they had to re-examine their views and position in a male-dominated society, and for the

project because suitable methodologies had to be identified. The training workshops did not result in a complete change in the views and practices of male health workers. Nor was this expected. The workshops and discussions did, however, start a process wherein male health workers began reflecting on the systemic nature of how gender operates, how their masculinities are constructed, and the effects of gender issues on reproductive and sexual health, The men's involvement committee' and the module preparation committee' that met at least once a month, provided the necessary space for male health workers to carry the discussions further.

The workshops and training sessions organised by WCHP served a purpose beyond the intended one of imparting knowledge and skills to enable male health workers to discuss gender, sexuality and health during their work. The workshops organised for them by 'workplace trust', as conceptualised by Gilson et al., resulted in their taking initiative as health care providers and an improvement in 'patient-provider trust' (Gilson et al. 2005).

The experience of working with male health workers also highlights that issues related to sexuality cannot be incorporated into health care provision, unless health providers are sufficiently enabled to talk about these issues. The inadequacies and low self esteem of male health workers were addressed by providing them with the necessary information, and the non-judgemental space to explore their internalised notions of male and female sexuality, as well as communication and counselling skills to talk about sexuality and sexual health issues with men and women in the community. Value clarification around their own masculinities and sexualities was an important part of their transformation. Similar experiences have been reported in the context of integrating HIV/STD prevention with family planning by International Planned Parenthood (Helmer; Roitstein 1995). These kinds of approaches represent a move away from a top-down biomedical approach to a rights-based, gender-sensitive approach. Transformatory training processes, as suggested in this chapter, take time, and resources to support them have to be budgeted for.

The multi-pronged approach employed by the WCHP involved boosting male health workers' self esteem, encouraging them

to re-examine their role in reproductive and sexual health services, providing them with skills and knowledge to fulfill these responsibilities, and creating spaces for them to employ the skill and to share their experiences. This proved useful in effectively reaching out to what is commonly perceived as a problematic cadre of health providers in India. Career advancement opportunities, and professional and personal development may work as motivators and help transform this cadre of health providers, into productive agents of change. The WCHP experience clearly demonstrated that male health providers can be trained on gender, sexuality, rights and health through appropriate methodologies. What is important is that the male providers should feel valued as human beings and realise that they have the potential to be effective change agents for transformative masculinities.

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Poems

Gieve Patel

Public Hospital

How soon I've acquired it all!
It would seem an age of hesitant gestures
Awaited only this sententious month.
Autocratic poise comes natural now:
Voice sharp, glance impatient,
A busy man's look of harried preoccupation —
Not embarrassed to appear so.
My fingers deft to manoeuvre bodies,
Pull down clothing, strip the soul.
Give sorrow ear upto a point,
Then snub it shut.
Separate essential from suspect tales.
Weed out malingerers, accept
With patronage a steady stream
Of the underfed, pack flesh in them,
Then pack them away.

Almost,
I tell myself,
I embrace the people:
Revel in variety of eye, colour, cheek, bone;
Unwelcome guest, I may visit bodies,
Touch close, cure, throw overboard
Necessities of distance, plunge,
Splice, violate,

With needle, knife, and tongue,
Wreck all my bonds in them.
At end of day,
From under the flagpole,
Watch the city streaming
By the side of my hands.

Catholic Mother
(Your Child at Hospital)

'She's the youngest of three,' you said,
'She's always been so: sickly',
And you smiled; the child
Responded but turned shyly away.
We were all three
Barely perturbed.

And so you were trustful,
Open, not alien to objects,
Touching cups, bottles,
Her hair,
Shared by the sunlight
That was breaking over the weeds,
And peaceful
That your child was breathing in
The quiet afternoon dazzle.

But then when it struck,
When her eyes began
To paper, and drugs
Were ineffective,
The room recoiled
And I saw you become
Private, before relations
Could come
To join into your pain.

I can see that your people
Have more right to you now than I,

Aunts and uncles will be closer,
But before I let you leave, pious woman,
Your weeping soft,
Unrebellious,
From what perverseness
Do I appose for you
Your simple original trust
Before the present horror?

Post-Mortem

It is startling to see how swiftly
A man may be sliced
From chin to prick,
How easily the bones
He has felt whole
Under his chest
For a sixty, seventy years
May be snapped,
With what calm
Liver, lung and heart
Be examined, the bowels
Noted for defect, the brain
For haemorrage,
And all these insides
That have for a lifetime
Raged and strained to understand
Be dumped back into the body,
Now stitched to perfection,
Before announcing death
Due to an obscure reason.

From *POEMS*, Bombay: Nissim Ezekiel, 1966.

The Multitude Comes To A Man

The multitude comes to a man
When he acquires the power
To heal: slowly the multitude
Comes dragging
Its heel. What
Can the multitude want
As I join it to visit
The man who can heal?
The multitude sees its own power
Accumulate before
The healing man, and exchanges
Willingly power
For power.

Notes on Editors

Kabir Sheikh works at the Public Health Foundation of India, New Delhi, where he teaches health policy and ethics; his research focuses on health systems and policy processes in low- and middle-income countries. Previously, he worked for DfiD's Resource Centre for Sexual Health & HIV/AIDS, Delhi; the Centre for Health Research & Development, Pune; and Maulana Azad Medical College, Delhi. He has been a frequent consultant to the WHO on the Public Private Mix for TB Control, and has been associated with the DfiD research consortia at the London School of Hygiene and Tropical Medicine (LSHTM) for several years. Sheikh has published extensively in scientific journals, and written key policy instruments for the WHO's STOP TB Department (National Situation Assessment tool for PPM-TB) and India's National AIDS Control Programme (Tribal Action Plan). He is trained in medicine (University of Delhi) and public health, and has a PhD in Health Policy from the LSHTM.

Asha George is engaged with reproductive and child health, health systems and gender analysis. She is responsible for Community Based Approaches for Health Policy and Evidence at UNICEF, New York. Prior to UNICEF, she primarily worked with Gita Sen and Aditi Iyer at the Indian Institute of Management, Bangalore (IIM-B), conducting research and facilitating community and health system responses for safe motherhood. She also coordinated a national network — the Coalition for Maternal-Neonatal Health and Safe Abortion — and undertook assignments for the WHO Social Determinants of Health Commission, DAWN, the Packard Foundation, DFID and the World Bank, among others. Apart from publishing in national and international journals, she is an editorial advisor for the journal *Reproductive Health Matters* and a co-editor with Gita Sen and Piroska Östlin of *Engendering International*

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Paramita Chaudhuri has been working on issues related to gender, sexuality, reproductive rights and mental health. Her areas of experience include research, documentation, impact evaluation and training. She has been working for several years on sexual harassment at the workplace and has assisted organisations in developing policies and training curriculum for employees at different levels. She has a Masters degree in Sociology and was a fellow of the Health and Population Innovation Programme administered by the Population Council, New Delhi. She has done a course on Sexuality, Culture & Rights from the Summer Institute of Amsterdam, University of Amsterdam, and a subsequent course on Reproductive health & Development from the Bill & Melinda Gates Institute for Population & Reproductive Health at the John Hopkins Bloomberg School of Public Health.

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Risha Hess has an MBA from Georgetown University. Her focus on bringing successful business practices into the social work world has led her to work in public health in the US, throughout Asia and now Africa, including four years in India. She was Communication Director for PSI's Male Client Intervention, specialising in behaviour change communication in India. As part of this programme she uses extensive qualitative and quantitative research to understand and monitor trends in the treatment, seeking behaviour of men for sexually transmitted diseases and in attitudes and practices of a network of approximately 900 socially franchised privately practicing health care practitioners in southern India. She is currently Reproductive Health Regional Marketing Advisor, covering Kenya, Tanzania, Uganda and Nigeria for PSI.

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This volume brings together contributions featuring research, comment and analysis on health care providers — doctors, nurses, public health workers, counsellors, traditional practitioners and homecare providers. The ideas and themes that emerge contribute to the understanding of providers' roles as actors in the health systems and societies of contemporary India, and re-examine preconceptions about this critical occupational group.

Different groups of health providers face struggles at diverse frontiers — social, professional and systemic; for instance, in reforming health systems, government health workers must constantly negotiate the vagaries of changing working environments and policy vacillations. Formal health systems and structures often reject and exclude the contributions of traditional and homecare providers. Medical doctors, conversely, face challenges of introspection, as they tread the line between personal gain and public service.

Contributed by health researchers, practitioners, policy advocates, programme managers and a journalist, each article presents a distinctive view of a particular group of frontline health providers, based on field research or on the authors' respective experiences of working with or as providers. Four poems by the renowned poet–physician Gieve Patel conclude the volume. Advancing the case for a fuller appreciation of the complex landscape of health care provision in India, the volume locates frontline health providers as central figures in development. The book will interest scholars of sociology, development studies, development economics, policy studies and, more specifically, readers with an interest in health management, health policy and public health in low- and middle-income countries.

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